MADISON
General Insurance

HEAD OFFICE:
Upper Hill Close,
P. O. Box 46666 - 00100, Nairobi
Tel: 020 - 2844000 / 0709 922 000
Emergency Line: 0715 992 952

Email: gibclaimsdepartment@madison.co.ke
Web: www.madison.co.ke
Dial *828# and select pay premium
MPESA Paybill: 880928

PERSONAL ACCIDENT CLAIM FORM

(All questions in this form must be answered in block letters and in the claimant's own handwriting or to his dictation)

AGENCY: _____ **TELEPHONE:** _____ **E-MAIL:** _____

POLICY NUMBER: [ ]

Ensure that both the Claim Form and the Medical Certificate are properly completed.

Supporting documents or copies thereof plus original medical bills incurred, if any must be submitted with the Claim Form.

1. Name of Insured: _____
2. Name of Claimant:. _____
3. Postal Address: _____ Postal code _____
4. Main Telephone Number: _____ Alternative Telephone Number:_____
5. Email: _____
6. Occupation: _____
7. Date of Birth: _____
8. Date of Payment of last premium:_____
9. Date of Accident: _____
10. Where did the accident occur?_____
11. Describe fully how the accident happened _____

    _____

    _____

    _____

    _____
12. Give the name, address and occupation of a witness of the accident

    Name: _____

    Address: _____

    Occupation: _____

    Telephone number: _____

(Please turn over to the next page)

13. Describe the nature and extent of the injuries you have received and attach a medical report, if available.

_____

_____

14. Give names and address of the doctor and hospitals who have attended to you for these injuries.

_____

_____

15. State the number of days you have been ENTIRELY confined to your bed, room or house.

To bed for _____ days from_____ To _____

To house for _____ days from _____ to _____

16. If you are still confined to your bed, room or house. State which:- _____

17. State the extent and duration of your inability to attend to your business or occupation:-

I have been disabled

PARTIALLY for _____ Days from _____ to _____

WHOLLY for _____ days from _____ to _____

I am now: Wholly disabled ☐ Partially disabled ☐ Not at all disabled ☐

18. If still disabled, state how much longer the disability is likely to continue:_____

_____

19. Have you since the accident, personally directed or supervised or given any attention whatsoever to any part of your business or occupation? If so, give full particulars and dates:- _____

_____

20. Are you entitled to receive compensation from any other Company or other source in respect of the accident? If so, give full particulars and dates:- _____

_____

21. Have you ever claimed compensation before, from any other company in respect to any previous injuries? If so, give full particulars and dates:- _____

_____

22. State the monthly earnings for the month prior to date of accident; Ksh._____

Declaration:

I, the undersigned, hereby declares that am the person referred to in the above statement, which is true in every respect, and made without reservation. I hereby authorize **Madison General Insurance Kenya Limited** to apply to any medical attendant mentioned above, for a report to be furnished at my expense as the form used by **Madison General Insurance Kenya Limited** for the purpose.

Date:._____ Signature of Insured _____

(If the insured is a Company, a stamp should be placed over the signature)

Note: The Medical Certificate must be completed by your doctor before the Claim Form is forwarded to **Madison General Insurance Limited**

MEDICAL CERTIFICATE

In order to establish his claim, the Claimant must obtain and forward to **Madison General Insurance Kenya Limited** a certificate from a duly qualified and registered Medical Practitioner. It is essential that this form be filled up as minutely as possible so that the Medical Officer of **Madison General Insurance Kenya Limited** may properly understand the nature of the case.

The Medical Attendant of the Claimant is requested to state:-

1. Name of the Claimant in full: _____
2. Occupation of the Claimant:_____
3. The exact nature and extent of the injuries caused by the accident and state the part an arm, afoot or leg,
4. State whether it is the right or left.

   Part injured: _____

   Nature and extent of injury: _____
5. Has the Claimant suffered or is he now suffering from any disease or physical infirmity?

   Yes. ☐ No. ☐ If Yes, state the nature of such disease or infirmity and to what extent it affects the disablement. _____

   _____
6. When the Claimant first attended? _____
7. Where was the Claimant first attended? _____
8. Are you still attending him? If so, give a brief explanation:- _____

   _____
9. State to what the extent the above accident injuries have necessarily disabled the Claimant from giving attention to business:-
10. Claimant have been disabled:-

    PARTIALLY for _____ Days from_____ to _____

    WHOLLY for _____ days from_____ to_____

    Claimant is now: Wholly disabled ☐ Partially disabled ☐ Not at all disabled ☐
11. The further disability (if any) will in my opinion continue:

    For_____ entirely from the present time

    For_____ partially from the present time
12. Total disablement arises when the Claimant is rendered completely incapable of attending to any part of his ordinary profession, business or occupation. Partial Disablement arises when the Claimant is a injured, or has so far recovered from injuries as to be capable of attending to some portion of his ordinary profession, business or occupation.

    a) If the Claimant is now, in any way, attending to business, on what day did he first commence doing so after the accident? _____

    b) If not, do you consider the Claimant fit personally to perform his / her business or occupation?

    _____

(Please turn over to the next page)

13. Was any intoxicating liquor and /or drugs (prescribed or otherwise) consumed by the claimant within 12hours before the accident? Yes ☐ No ☐

If Yes, give details:- include time, quantity and place _____

_____

_____

14. Is there any information, professional or otherwise, that you consider should be known to **Madison General Insurance Kenya Limited?** _____

_____

_____

_____

Additional remarks (if any) _____

_____

_____

_____

16. **DECLARATION:-**

I certify that I have satisfied myself by personal examination that the Claimant has sustained an accident causing injuries as above described.

Qualifications: _____

Address: _____

Date: _____ Signature of Medical Attendant _____