UBL INSURERS LIMITED

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24/7 MUHAFIZ ACCIDENT INSURANCE CLAIM FORM

Policy No. _____ **Claim No.** _____

This form is issued without admission of liability, and must be completed and returned within **seven days after its receipt.** No claim can be admitted unless a medical certificate overleaf be furnished at the expense of the claimant.

1.	Name in full _____ Residence _____ Business Address _____ Present Business or occupation _____ (if more than one state all)	Present Age: _____ Years. Height _____ ft. _____ in Weight _____ st._____ lbs.
2.	(a) When did accident occur? State day, date, and hour (b) Where did it occur ? (c) Give full particulars of the cause, and the injuries sustained.	
3.	Give names and addresses of any witness of the Accident	
4.	(a) Give name and address of the Doctor who attended you (b) Name and address of your Ordinary Medical Attendant	
5.	State where and when a Medical or other officer of the Company can visit you, if necessary	
6.	(a) State the number of days you have been necessarily and entirely confined to bed, Room or House, as the sole and direct result of the injuries sustained b) If still confined to any, state which. (c) Have you in any way attended to business or work during the above period ?	**To Bed** for _____days From_____ to_____ (both inclusive) **To Room** for _____days From_____ to_____ (both inclusive) **To House** for _____days From_____ to_____ (both inclusive)
7.	Have you previously claimed or received compensation under an accident and/or sickness policy? If so please give particulars.	
8.	(a) Are you insured elsewhere ? (b) If so, give the name of each company or Insurer, and amount you are entitled to Claim	

I hereby declare that I have sustained the injuries above described, and warrant the truth of the foregoing particulars in every respect, and I agree that I have made, or if I shall make, any false or untrue statement, suppression or concealment, my right to compensation shall be absolutely forfeited.

I claim to be paid the sum of _____ per week, or the total sum _____ which I agree to accept in full settlement of my claim on the Company.

_____
Signature

UBL INSURERS LIMITED

Private and Confidential

Medical Certificate

Policy No. _____ **Claim No.** _____

NOTE: The form to be completed by Claimant's Medical Attendant whose replies should be as full as possible.

1.	CLAIMANT - Name in Full	
2.	The nature and extent of injuries (if to a limb, state whether right or left).	
3.	The cause of the accident so far as known to you.	
4.	(a) Date of your first attendance upon him in consequence of the injuries sustained. (b) Are you still in attendance?	(a) (b)
5.	Are you his usual Medical Attendant, and, if so, how long have you known him, and for what have you attended him?	
6.	a) Are his symptoms (i) due exclusively to the accident, or (ii) traceable to disease infirmity or any other cause? .... b) Has he ever suffered from Gout, Rheumatism, Diabetes or Fits? .... c) Is there anything in his medical history which may have contributed, directly or indirectly, to the accident, or which may be likely to retard his recovery? d) Have you any reason to suppose that he was under the influence of intoxicants at the time of the accident?	(a) (i) (ii) (b) (c) (d)

7. State the time, within your own knowledge that the Claimant has been, as the direct and sole consequence of the injuries sustained, necessarily confined to his bed, if still so confined, state to which and the probable duration of confinement to each.	To Bed	To Room	To House
	FROM_____ TO_____ (BOTH INCLUSIVE)	FROM_____ TO_____ (BOTH INCLUSIVE)	FROM_____ TO_____ (BOTH INCLUSIVE)

8.	a) Has he been able to attend to any portion of his business or occupation? (b) If so, from what date? .... (c) If not, please state probable date. (i) of his being so able .... (ii) of his complete recoveries	(a) (b) (i) (ii)
9.	Is there now any disability? If not, please give date of recovery	
10.	Any further remarks	

I hereby certify that the above-named with the accident referred to, and that the foregoing statements are correct.

Signature _____ Qualification _____

Address _____ Date _____

TOTAL DISABLEMENT occurs when the Insured is wholly prevented from attending to his business or occupation.
PARTIAL DISABLEMENT when prevented from attending to a substantial portion thereof.