Phoenix
Of Swaziland Assurance Company Ltd.
P.O. Box A113 Swazi Plaza – Corporate Place, Mbabane H101, Swaziland
Email: info@phoenixswaziland.com

PERSONAL ACCIDENT CLAIM FORM

(ALL QUESTIONS ON THIS PAGE MUST BE ANSWERED AND FORM SENT BACK IMMEDIATELY)

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1 INSURED ..... ADDRESS .....

..... TEL NO. .....

POLICY NO. ..... AGENT/BROKER .....

NAME OF INJURED PERSON .....

ADDRESS .....

OCCUPATION ..... AGE .....

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2. HOW DID THE ACCIDENT HAPPEN? (PLEASE STATE FULLY)

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3. WHEN & WHERE DID THE ACCIDENT OCCUR?

a) Date ..... b) Time .....

b) Place .....

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4. WHO WITNESSED THE OCCURRENCE?

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5. NATURE OF INJURIES

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6. HAVE YOU BEEN TOTALLY AND COMPLETELY DISABLED AS A RESULT OF THE INJURIES RECEIVED .....

7. WHEN DID (a) Total Disablement commence .....
(b) Confinement to the house commence? .....

8. ARE YOU AT THE PRESENT TIME

a) Totally Disabled .....
b) Confined to the house .....

9. a) WHEN DO YOU ANTICIPATE BEING ABLE TO LEAVE THE HOUSE .....
b) WHEN DID YOU RESUME AT LEAST PART OF YOUR DUTIES OR ATTEND TO SOME PORTION OF YOUR BUSINESS? .....

10. GIVE NAME AND ADDRESS OF THE DOCTOR WHO ATTENTED TO YOU IMMEDIATELY AFTER THE ACCIDENT?

11. a) WHO IS YOUR USUAL MEDICAL ATTENDANT?
.....

(b) HAVE YOU CONSULTED HIM IN RESPECT OF YOUR PRESENT INJURIES? .....

(c) WHEN DID YOU LAST CONSULT HIM PRIOR TO THIS ACCIDENT AND FOR WHAT PURPOSE?
.....

I/We hereby declare the above to be True and Correct to the best of my/our knowledge and belief.

Date: ..... Signature of Insured: .....

If Limited Company, give status of signatory .....

PLEASE HAVE MEDICAL CERTIFICATE PRINTED ON NEXT PAGE DETACHED FOR COMPLETION

MEDICAL CERTIFICATE

To be detached and completed by the Doctor upon Total Recovery of the Patient
(To be furnished at the expense of the injured person)

1. NAME OF PATIENT

2. WHAT INJURIES HAS THE PATIENT SUSTAINED?

3. WHEN WERE YOU FIRST CONSULTED?

4. i) HOW LONG HAS THE PATIENT BEEN TOTALLY DISABLED FROM ENGAGING IN OR ATTENDING TO USUAL PROFESSION OR OCCUPATION AS THE RESULT SOLELY OF THE INJURIES?

   i) Totally from ..... TO .....

   ii) HOW MUCH LONGER DO YOU CONSIDER SUCH DISABLEMENT WILL CONTINUE?

   ii) TOTALLY FROM ..... TO .....

   iii) WHEN DO YOU ANTICIPATE THE PATIENT WILL RESUME PART OF HIS DUTIES?

   iii) .....

HAS THE PATIENT ANY DISEASE OR ANY PHYSICAL DEFECT AND IF SO, OF WHAT NATURE?

6. TO WHAT EXTENT MAY RECOVERY BE AFFECTED THEREBY?

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7. i) HAS THE PATIENT SUSTAINED PERMANENT DISABLEMENT? i)

ii) IF SO WHAT IS THE PERCENTAGE OF PERMANENT DISABLEMENT? ii)

NAME ..... QUALIFICATIONS .....

SIGNATURE ..... DATE ..... 20.....

ADDRESS .....

OFFICIAL DATE STAMP