SHIKHAR INSURANCE COMPANY LTD.

Head Office : Shikhar Biz Centre, Thapathali, P. O. Box No. : 10692, Kathmandu, Nepal.
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CLAIM FORM
PERSONAL ACCIDENT INSURANCE

Policy No. : ..... Claim No. : .....

This Claim 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 the MEDICAL CERTIFICATE OVERLEAF is furnished.

INSURED

1 Name in full :

Address :

Tel No. :

EMPLOYEE

2 Name : Age :

Home Address :

Occupation : Monthly Earnings : Rs.

The average weekly amount paid by the insured to the Employee during the twelve months preceding the accident of during any shorter period of employment.

3 a. Date and Time of Accident :

b. Where did it occur? :

c. Details of the cause :

d. Injuries sustained :

4 Name and Address of any witness

5 a. Name and Address of attending doctor :

b. Name and address of employee's ordinary medical attendant.

6 a. Period during which employee has been totally disabled for work as the sole and direct result of the accident. :

b. Is employee still disabled? If so, when does he expect to return to work? :

I / WE HEREBY DECLARE that the above named employee received the above described injuries and that to the best of my / our knowledge the foregoing particulars are in every respect true.

Date .....

Signature

MEDICAL CERTIFICATE TO BE COMPLETED BY EMPLOYEE'S DOCTOR

I CERTIFY that .....

Was injured on .....

His injuries are .....

.....

If his injuries are complicated by any other conditions, give details .....

.....

He is disabled totally / partially and will be so disabled until .....

Name :

Signature :

Date :

Total Disablement occurs when the Employee is wholly prevented from attending to his business or occupation.