Allianz Insurance Company of Kenya Limited

CLAIM FORM – GROUP PERSONAL ACCIDENT

NOTE: This form must be completed and returned immediately to the above address.

Policy Number: ……………………………………………………………………………………………….

Name of Insured: ……………………………………………Tel No. …………………………………

Address: ……………………………………………………………………………………………………

Nature of Business………………………………………………………………………………………..

Employer's Signature……………………………………………………………………………………..

DETAILS OF INJURED EMPLOYEE

1. Full Name………………………………………………………………………………………………

2. Address………………………………………………………………………………………………….

……..

……

3. Occupation ……………………………………………………4. Age…………………………………

5. Monthly earnings………………………………………………………………………………………..

6. How long has the employee worked at your company……………………………………

7. When was the injured employee's last day of work after the accident?…………………

ACCIDENT DETAILS

7. The Incident took place at……………………..am/pm on the…………………………day of

……………………………at (state accident location)…………………………………………………

8. Give details of how the Accident happened

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…….

…….

…….

…….

9. The employee sustained the following injuries:

…….

…….

13. Contact names and addresses of witnesses to the accident

a. Name………………………………………………..Address…………………………………….

……………………………………………………………………………………………………...

b. Name ………………………………………………..Address…………………………………….

……………………………………………………………………………………………………….

c. Name………………………………………………..Address…………………………………….

……………………………………………………………………………………………………….

d. Name………………………………………………..Address…………………………………….

……………………………………………………………………………………………………….

DECLARATION:
I/We declare that the above information provided is accurate.

Date: ……………………………Signature of Insured & Co Stamp………………………………….