



# NEW JUBILEE INSURANCE COMPANY LIMITED

Jubilee Insurance House, I.I. Chundrigar Road, Karachi - Pakistan  
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## ACCIDENT / SICKNESS CLAIM FORM

This form must be fully completed and returned within seven days  
and a Medical Certificate must be furnished without expense to the Company.  
The issue of this Claim Form is in no way an admission of liability.

### PARTICULARS OF CLAIM

		Policy No.	_____
		Claim No.	_____
1.	Name of Insured	Date of Birth	_____
	Address	Phone No.	_____
	Present Occupation	Payment date of last premium	_____
2.	Name of Insured Person (if other than Insured)	Date of Birth	_____
	Address	Phone No.	_____
	Present Occupation		_____

3. **ACCIDENT**

a) Place and date \_\_\_\_\_

b) What happened \_\_\_\_\_  
nature of injuries \_\_\_\_\_

4. **SICKNESS**

a) Nature of sickness \_\_\_\_\_

b) Date of onset \_\_\_\_\_

5. **GENERAL** **To be completed for both Accident & Sickness Claims.**

a) Date on which ceased working \_\_\_\_\_

b) Have you since been able to supervise or give any attention whatever to any part of your business or occupation, if so, from what date \_\_\_\_\_

c) Date on which resumed working \_\_\_\_\_

d) Are you insured against accident or sickness with any other Company \_\_\_\_\_  
If so, give name & amount of benefit \_\_\_\_\_

e) Have you previously suffered from \_\_\_\_\_

i) The above trouble? \_\_\_\_\_

ii) Any other injury or sickness? \_\_\_\_\_  
If so, give particulars with approximate date & period of incapacity. \_\_\_\_\_

f) Do you suffer from any other physical defect or infirmity? If so, give details \_\_\_\_\_

6. Name & Address of your "Private Medical Attendant" \_\_\_\_\_  
\_\_\_\_\_

**DECLARATION**

**I hereby warrant the truth of the above statements and agree that the Insurers may seek information from the above doctor or from any doctor who has attended me.**

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Insured Person

# MEDICAL CERTIFICATE

Claim No. \_\_\_\_\_

In order to establish a claim it is essential that the Medical Attendant of the Claimant should complete this form as fully as possible. Any fee charged for this certificate is not covered by the Insurance Policy, and the form must be completed free of expense to the insurer.

1. Claimant's Name \_\_\_\_\_ Age \_\_\_\_\_  
Occupation \_\_\_\_\_

2. How long have you been the Claimant's usual medical attendant? \_\_\_\_\_ Date you first saw the Claimant in connection with this accident or illness \_\_\_\_\_  
Are you still attending?  Yes  No If still attending, date last seen \_\_\_\_\_

3. **ACCIDENT**  
Precise nature and extent of injuries \_\_\_\_\_

4. **SICKNESS**  
a) Precise nature of illness \_\_\_\_\_  
b) Its origin and cause \_\_\_\_\_

<p>5. <b>GENERAL (to be completed for both Accident &amp; Sickness Claims)</b></p> <p>a) Claimant has been disabled from following the above occupation Totally from _____ to _____ Partially from _____ to _____ Insert actual dates</p> <p>b) Further disablement (if any) will in my opinion continue for Totally _____ Partially _____</p>	<p style="text-align: center;"><b>TOTAL DISABLEMENT</b></p> <p>arises when the Claimant is rendered completely incapable of attending to any part of his/her ordinary profession, business or occupation.</p> <p style="text-align: center;"><b>PARTIAL DISABLEMENT</b></p> <p>arises when the Claimant has so far recovered to be capable of attending to some portion of his ordinary profession, business or occupation including supervision.</p>
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<p>6. Has the Claimant previously suffered from</p> <p>i) the above trouble <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>ii) Any other accident or illness which affects the present disablement? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If the answer to (i) or (ii) is "YES" state</p> <p>a) Its nature _____</p> <p>b) The period(s) involved _____</p>
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7. Does the Claimant suffer from any physical defect or infirmity or show symptoms of being affected by any particular illness apart from the present one? If so, give details:- \_\_\_\_\_

8. **REMARKS**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I CERTIFY THAT I HAVE SATISFIED MYSELF BY PERSONAL EXAMINATION THAT ALL THE FOREGOING STATEMENTS ARE CORRECT.

Signature \_\_\_\_\_ Qualifications \_\_\_\_\_

Address \_\_\_\_\_

Date \_\_\_\_\_