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PERSONAL ACCIDENT CLAIM FORM

This form should be completed and returned within seven days of its receipt by the insured

PARTICULARS OF CLAIM

- Name of Insured in full _____
Business Address _____
Resident Address _____
Profession or Occupation _____ Present age _____ Years.
Policy No. _____ Date of payment of last premium _____
1. State when and where did the Accident take place Date _____
Time _____
Place _____
 2. State how it happened, and what you were doing at the time.
(It is necessary that fullest details be given) _____
 3. State (a) What injuries you have sustained. _____
(b) Whether you have ever had an
injury to the same part before. _____
 4. Are you insured elsewhere against Accidents? _____
If so give particulars. _____
 5. Give the name and address of any Witness of the Accident _____
 6. (a) Give the name and address of the Medical Man who attended you on your meeting
with the accident. _____
(b) Is he your usual Medical attendant : _____
(c) How he or any other Medical Man, attended you during the last five year for any
illness or injury? I so give particulars. _____
 7. Have you, as the direct result of the
Accident, bee totally incapacitated from attending
to business or any kind: If so, state for how long? From _____ to _____
 8. Are you still totally incapable of attending to business of any kind: _____
 9. State if (a) Confined to bed From _____ to _____
(b) Confined to house From _____ to _____
(c) Able to get out of doors From _____ to _____
 10. If now able to attend to any portion whatever of our business or occupation, state when you
commenced to do so. _____
 11. How you fully resumed your usual business or occupation? If so, since when. _____
 12. When and where can you be visited by our Medical or other officer: _____
Name nearest Railway Station & Distance there from: _____
 13. If you are prepared to agree to an immediate settlement
please state the amount you are willing to accept. _____

I HEREBY WARRANT THE TRUTH OF THE FOREGOING STATEMENTS.

Date _____ 20____

Signature _____

No claim can be entertained without the certificate of a duly qualified & registered Medical Practitioner.



NEW JUBILEE INSURANCE COMPANY LIMITED

MEDICAL CERTIFICATE

1. Name of Claimant:	
2. So far as you aware, how did the injury arise:	
3. When did he first consult you in connection with this accident:	
4. Are you still in attendance:	
5. Are you usual Medical Attendant If so, how long have you know to him	
6. Please state fully the nature of the injuries sustained. (If it is a limb or eye injured state whether right or left.)	
7. Are the symptoms from which he suffers due to the accident alone?	
8. Is the Claimant suffering from any disease in addition to the present injuries or has he any physical defects.	
If so, state the nature of same and to what extent the recovery may be affected thereby.	
9. State if the Claimant by your advise is : a) Confined to Bed b) Confined to House c) Able to get out of doors.	
10. If the Claimant is in you opinion unable to give any attention to his profession or occupation, as described on the front page, please state:	
Date of Commencement of partial disability.	
Probable future duration.	
11. In the event of the Claimant being able to give partial attention to such profession or occupation please state:	
Date of Commencement of partial disability.	
Probable future duration.	
12. If recovered please state date of recovery.	
13. General remarks.	

I CERTIFY THAT TO THE BEST OF MY BELIEF THE FOREGOING STATEMENTS ARE CORRECT.

SIGNATURE: _____

Date : _____



NEW JUBILEE INSURANCE COMPANY LIMITED

PERSONAL ACCIDENT CLAIM FORM

1. Name and Present Address _____
2. Date of last medical attendance. _____

3. State how long you have been :
 a) Confined to house From _____ to _____
 b) Partially disabled. From _____ to _____
4. How long have your been:
 a) Totally disabled From _____ to _____
 b) Able to get out of doors. From _____ to _____
5. If you are prepared to agree to an immediate settlement please state the amount you are willing to accept. _____

I HEREBY WARRANT THE TRUTH TO THE FOREGOING STATEMENTS.

SIGNATURE: _____

DATE : _____

NEW JUBILEE INSURANCE COMPANY LIMITED

MEDICAL CERTIFICATE

1. Are you still attending the Claimant. _____
2. What are his present symptoms? _____
3. How long has he been:
 a) Totally disabled. From _____ to _____
 b) Partially disabled From _____ to _____
4. How much longer is it probable that the claimant's present state of disability will continue. _____
5. GENERAL REMARKS. _____

I CERTIFY that to the best of my belief the foregoing statements are correct.

Signature _____

Qualifications _____

Address _____

Date _____ 20__