RASTRIYA BEEMA COMPANY LIMITED

PERSONAL ACCIDENT CLAIM FORM

INCLUDING SICKNESS (HOSPITALIZATION CASE ONLY)

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

This 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 _____

   Occupation _____ Tel./Mobile No. _____

   Home address _____

   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. If an accident	
(a) Date and Time of accident	_____
(b) Where did it occure?	_____
(c) Details of the cause	_____
(d) Injuries sustained	_____
4. If an illness	
(a) Date and time of admission to hospital	_____
(b) Details of illness	_____
5. Name and address of any Witness	_____
6. (a) Name and address of doctor who attended employee	_____
(b) Name and address of employee's ordinary medical attendant	_____
7. (a) Period during which employee has been totally disabled for work as the sole and direct rusult of the accident/illiness	_____
(b) Is employee still disabled ? If so, when does the expect to return to work?	_____

8. Details of Claim

Please fill up the items under which the benefits are claimed in respect of the above illness/accident giving amount claimed and closing receitp, bills, prescription and have the certificated completed by the Doctor giving the medical attention in respect of which a claim is made:

Benefit No.	Description of tTreatment Received	Cost of Treatment
A	Surgeon's and /or anaesthetist Fees	
B	Specialist and /or Pathologist Fees	
C	Charges for Nurses cabin etc.	
D	Charges for X-Ray and/or electric and/por massage	
E	Cost of any surgical appliances	
F	Cost of Medicines and drugs	
G	Pricate Doctor's Fees	
H	Charges for Acupunture	

MEDICAL CERTIFICATE TO BE COMPLETED BY EMPLOYEE'S DOCTOR

I CERTIFY that _____

was ill/injured on _____

His illness/injuries are _____

_____

If his illness/injuris are complicated by any other conditions, give details _____

_____

He is totally disabled and will be so disabled until _____

Signature of Doctor:

Name of Doctor :

NMA No. :

Date: .....

Qualification :

Specialist :

Toal Disablement occurs whien the Employee is wholly prevented from attending to his business or occupation.

I DECLARE that I have/my dependent/my employee has suffered the above described injuries/illness and that the best of my knowledge and belief the foregoing particulars are in every respect true. I declare there is not other insurance or other source to cover the items claimed. I also declare his/her salary and leave during the aforesaid Accident is as follows.

Signature :

Salary -per month) : Rs

Name :

Leave (from/to) :

Designation :

Office Stamp :

Date :