SALAM TAKAFUL INSURANCE COMPANY LIMITED
65, IBRAHIM TAIWO ROAD, KANO
Website: www.salamtakafulinsurance.com
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WORLD TRAVELER CLAIM FORM

Instruction: Use (✓) where appropriate.

This form should be completed and returned within seven days. It is necessary that questions overleaf be answered by a medical practitioner.

NOTE: The Company does not admit liability by the issue of this form.

PART A: POLICY DETAILS

POLICY NO: _____

Date of payment of last contribution: _ _ / _ _ / _ _ _ _ format dd/mm/yyyy

PART B: PARTICIPANT DETAILS

FULLNAME: _____ AGE: _____

PRIVATE ADDRESS: _____

BUSINESS ADDRESS: _____

TELEPHONE: _____

OCCUPATION/ BUSINESS: _____

PART C: ACCIDENT DETAILS

i- When did it Happen? Time: _ _: _ _ am/pm format HH:MM Date: _ _ / _ _ / _ _ _ _ format dd/mm/yyyy

ii- Where did it happen? _____

iii- How it happened and what you were doing at the time. The fullest particulars should be given;

_____

Authorized and Regulated by:

Member of:

iv- State as precisely as you can, what injuries you have sustained;

PART D: DOCTOR DETAILS

i- Doctor attending to you for thesaid injuries

(a) Name:

(b) Address:

ii- Is he your usual medical attendant? ☐ YES ☐ NO

iii- Had any other medical man been consulted? ☐ YES ☐ NO

PART E: OTHER DETAILS

i- Have you been totally unable to attend to your business or occupation? ☐ YES ☐ NO

If yes, state the period during which you are totally disabled: From _ _ / _ _ / _ _ _ _ to _ _ / _ _ / _ _ _ _ inclusive.

ii- Are you still totally unable to attend to your business or occupation?

☐ A portion of your occupation ☐ The whole of your usual occupation

iii- When and where can be visited by the Medical Officer or Other Officer of the Company?

(a) When: Time: _ _: _ _ am/pm format HH:MM Date: _ _ / _ _ / _ _ _ _ format dd/mm/yyyy

(b) Where:

PART D: OTHER TAKAFUL/INSURANCE DETAILS

i- Are you entitled to claim under any other insurance/Takaful? ☐ YES ☐ NO

If yes, give details

ii- Have you ever claim compensation from any Accident Company? ☐ YES ☐ NO

If yes, state name of Company, amount and date received;

(a) Name:

(b) Amount: ₦

(c) Date received: _ _ / _ _ / _ _ _ _ format dd/mm/yyyy

PART E: DECLARATION

I do hereby solemnly and sincerely that the foregoing statements and particulars are true, and that I will not abstain from. And have not abstained from following my usual occupation, either totally or partially, for a period than necessary.

Date: _____ Signature: _____

MEDICAL CERTIFICATE

Instruction: Use (✓) where appropriate.

Note: The Claimant must obtain at his own expense, the following Certificate from a dully qualified and registered medical practitioner.

1. Name of patient in full: ☐

2. When did you first attend upon the Claimant in consequence of the injuries sustained;

   Time: _ _: _ _ am/pm format HH:MM Date: _ _ / _ _ / _ _ _ _ format dd/mm/yyyy

3. Are you still his attendant? ☐ YES ☐ NO

4. Are you his usual Medical Attendant? ☐ YES ☐ NO

   If so how long have you known him? ☐ Years ☐ Months

5. What was the cause of the Accident, so far as known to you?

   ☐

6. What injuries were sustained?

   (a) Regions injured: ☐

   (b) Nature and extent of Injuries

   ☐

   (c) Are the symptoms from which he suffers due to;

   (i) The Accident alone? ☐ YES ☐ NO

   (ii) Are they traceable to any other cause? ☐ YES ☐ NO

7. Is he now or as he is the time of the accident, subject to or suffering from any illness or disease irrespective of the injuries? ☐ YES ☐ NO

   If yes, state the nature of same, and to what extent his recovery may be affected thereby;

   ☐

8. Are you aware of anything in his previous medical history which might have contributed, directly or indirectly, to the occurrence of the Accident, or which may be likely to retard in anyway his recovery from it? ☐Yes ☐No

   If yes, give details;

   ☐

9. Is he now, or has he been at any time since the date of the Accident totally disable from attending to his business or occupation? ☐ YES ☐ NO

   If so, give the dates: From _ _ / _ _ / _ _ _ _ To _ _ / _ _ / _ _ _ _

10. If he has been able to attend to a portion only of his usual business or occupation, please state when and also the probable date of recovery;

    (a) Period business was attended: From _ _ / _ _ / _ _ _ _ To _ _ / _ _ / _ _ _ _

    (b) Probable date of recovery: _ _ / _ _ / _ _ _ _

11. If the Claimant has recovered, please state date of recovery _ _ / _ _ / _ _ _ _

12. General Remark

Assessment of permanent Disability is ……. %

ADDRESS: ..... Qualification: .....

Signature: ..... Date: .....20.....

TEMPORARY TOTAL DISABLEMENT occurs when, through accidental bodily injury the Claimant is directly and wholly incapacitated from engaging in, or giving attention to his usual business or occupation.

TEMPORARY PARTIAL DISABLEMENT arise when the injury received does not wholly prevent the Assured from attending to business, or when Total Disablement ceases and can be attend to some portion of his usual business or occupation but not the whole.