CLAIM FORM

THIS SECTION TO BE COMPLETED BY THE INJURED PERSON (OR ON THEIR BEHALF)

Policy Number: _____

Full Name: (Mr /Mrs/Ms) _____

Residential Address: _____

_____

Date of Birth: (DD/ MM/ YY) TRN: _____

Tel: _____ Other: _____

DETAILS OF INJURY

1. Date of accident: (DD/ MM/ YY)
2. What do you understand to be wrong with you?

   _____

   _____

   State the nature and date of earliest symptoms of this injury.

   _____

   _____
3. Kindly provide names, addresses and telephone numbers of all medical practitioners *(including specialists etc.)* consulted in connection with this injury.

   _____

   _____
4. When did you first consult a medical practitioner in connection with your current injury? (DD/MM/YY)
5. Name and address of your usual family doctor.

   _____

   _____

   _____

DECLARATION

I hereby authorize any medical practitioner, hospital or any other person to furnish the **INSURER** or its appointed representative, with any information relating to my illness or injury. I do hereby declare and warrant that the answers given by me in this report are in every respect factual, true and correct and that no material information has been withheld nor has any relevant information regarding the circumstances been omitted.

Name: _____

Signature: _____ Date: (DD/MM/YY)

Witness Name: _____

Signature: _____ Date: (DD/MM/YY)

THIS SECTION TO BE COMPLETED BY MEDICAL ATTENDANT

/e require an objective medical opinion of the impairment xperienced by your patient. Provide full details of all limitations in ıovement, use or restriction.

he details of all treatment from the elementary to the most dvanced will provide us with a full picture of the condition and its rogression.

hank you for your assistance in this claim, kindly provide us with ıe following information.

1. Diagnosis of patient's condition:

   _____

   _____

   _____
2. The cause of the patient's injury:

   _____

   _____

   _____
3. Date the patient was informed of the diagnosis (DD/MM/YY)
4. When did the patient experienced the earliest symptoms hereof? (DD/MM/YY)
5. Details of complications or concurrent conditions:

   a. Date of first consultation and treatment with regards to the patient's present medical condition (DD/MM/YY).

   b. Date of last consultation and treatment with regards to the patient's present medical condition (DD/MM/YY).
6. Names, addresses and contact numbers of any other medical practitioners who may be or have been consulted.

   _____

   _____

   _____
7. Full details of treatment from the date of first consultation to the current date, the results and the reasons, if any, for change.

   _____

   _____

   _____
8. Please provide details of other information, which may be useful to the company in assessing the customer's right to compensation for this injury:

   _____

   _____
9. Please provide us with copies of all investigations: Laboratory, Tests, Special Reports, Additional Documents, please state:

   _____

I/We declare that all the foregoing statements are true and correct.

Medical Qualification:_____ Practice #: _____

Certified Stamp: Date: (DD/MM/YY)

REMITCARE
CLAIMS PROCESSING DETAILS

Name of Injured person (Sender): _____

Name of Beneficiary (Receiver) : _____
(Person receiving payment)

Payment Method : (Please tick preferred payment option)

- **Bank Account :**
  Type of Account:_____
  Bank Name:_____
  Bank Branch:_____
- **Mpay:**
  Type of Account:_____
- **Western Union**

WHAT YOU ARE REQUIRED TO DO IN ORDER TO MAKE A CLAIM.

You are required to notify us of your accident within a maximum of thirty **(30) days** from the day it happened. All documentation required must be submitted within **(90) days** from the day of your accident.

Documents required:
- **Completed claim form**
- **Copy of identification and TRN (sender & receiver)**
- **Receipt or other proof of payment for expenses.**
- **Proof of death (Pronouncement/Burial Order/ Certificate)**

The insurer reserves the right to request any additional information required to validate a claim.