

PERSONAL ACCIDENT CLAIM FORM

PRIVACY NOTICE

By completing this form, you will have provided NCBA Insurance Company Limited (NCBA Insurance) with your Personal Data. Personal Data is any information that identifies you or other individuals named in this form. Please note that you should only provide Personal Data about someone else to us with the individual's express permission. NCBA Insurance will, in adherence to the principles of data protection, collect, store, use, transfer (including cross-border), and disclose certain Personal Data in connection with the provision of insurance services. You have a right to be informed of the use to which your Personal Data is to be put; a right to access your Personal Data in our custody and to request us transfer it to another organization; a right to object to the processing of all or part of your Personal Data; a right not to be subject to a decision based solely on automated processing; a right to correction of false or misleading data; and to deletion of false or misleading data about you. Detailed information about how we use Personal Data is set out in our Privacy Policy, which you can find at <https://ke.ncbagroup.com/privacy-policy/>.

SECTION A : PERSONAL / CORPORATE DETAILS

Name of Insured in full: _____
 P.O Box: _____ Postal Code: _____ PIN No.: _____
 Name of Contact Person: _____ Position: _____
 Name of Injured Party in full _____
 Occupation: _____ Mobile Phone: _____
 E-Mail Address: _____ Policy Number: _____

SECTION B : TECHNICAL DETAILS

NOTE: All supporting documents **MUST** be submitted together with this form in order to avoid any unnecessary delays.

SECTION 1

Date of Injury: _____ Place of Injury: _____
 Description of how accident/incident occurred: _____

SECTION 2

DEATH/PERSONAL ACCIDENT

Did you consult a Medical Practitioner? **(Tick the appropriate block)** YES NO

If YES, Name of Practitioner: _____ Tel. No: _____

SECTION B : TECHNICAL DETAILS

Privacy Consent

Where you have shared sensitive personal information, including your health status, property details, and family details, we require your explicit consent for cross-border transfer. By ticking the box below, you consent to the international transfer of the sensitive personal information for policy management, claims processing, and customer support. Your data will be protected under appropriate safeguards, and you may withdraw your consent at any time by contacting ncbainsurance@ncbagroup.com.

I consent I do not consent

Declaration

I/We declare that the above information is true and correct and that the signing of this claim form also constitutes written authority for NCBA Insurance to inspect or investigate any medical records or details relevant to this claim. I/we further declare that i/ we are aware that any misrepresentation and / or non-disclosure in respect of information provided herein shall render my/our claim null and void.

Name: _____

Signature: _____ Date: _____

(If Corporate)

Name: _____ Designation: _____

Company Stamp and Date

ATTENDING PHYSICIAN FORM

SECTION A : PERSONAL / CORPORATE DETAILS

Name of Claimant in full _____

SECTION B : TECHNICAL DETAILS

HISTORY

(a) When did present injury or illness begin? _____

(b) If accidental injury, give details of accident? Any evidence of visible contusion or wound? _____

(c) Was patient at time of this accident or during this disability affected with any **previous injury or any other disease?** YES NO

If yes, please give particulars _____

(d) To your knowledge did he have any infirmity or physical impairment prior to this accident, or disability? If so, did it contribute to cause the accident or prolong the disability? YES NO

(e) Was the operation performed? YES NO

If yes, please describe _____

(f) For what periods was patient	Hospital confined	From _____	To _____
	House confined	From _____	To _____
	Bed confined	From _____	To _____
	Ambulatory	From _____	To _____

DIAGNOSIS

If injury involved eye or limb, state whether right or left. If fracture or dislocation occurred, state which and whether compound, complete or incomplete. If fracture of long bones occurred, state whether through head or shaft.

TREATMENT

Date of first visit _____

Date of last visit _____

Total Number of visits _____

DESCRIBE PRESENT CONDITION

Indicate if recovered, improved or retrogressed. Also indicate percentage of permanent disability if applicable

DEGREE OF LENGTH OF DISABILITY

(a) From what dates has patient been unable to perform any part of his occupation? From _____ To _____

(b) From what dates has patient been unable to perform some part, but not all, of his occupation? From _____ To _____

(c) If not working, when do you think he will be able to work? Approx. Date _____

Indefinite

Never

SECTION C : DECLARATION

I certify that the foregoing statements are correct.

Doctor's Name: _____

Signature: _____

Company Stamp and Date: