

ANNEXURE I

CLAIM FORMS

a) Motor

1. POLICY HOLDER DETAILS
Policy NoCover note No
Period of insurance: fromto:
Name of the insured
Business/Occupation:
Telephone No:
Insured's email address:
Physical address:
2. DRIVER DETAILS
Name of driver:
Date of Birth
License no
Date obtained:
Was he / she in any way to blame for the accident ?
Did he / she admit liability ?
Does he / she own a Motor vehicle ?
3. VEHICLE DETAILS
Make:Year:
Reg No:Engine No:
Chassis No:Colour:Colour:
Are you the sole owner of the vehicle? Yes Yes No
If not, name of other interested parties/Financiers:
Name and address of owner
COMMERCIAL VEHICLES
Description of goods being carried
Name and owner of goods
Was the trailer attached?
5. LOSS /DAMAGE/THEFT DETAILS
Date & TimeSpeed:
Place:
Type of road surface
Purpose for which the vehicle was being used at the time of accident:
If only parts were stolen from the vehicle, please give full
details:
Was the accident reported to the police? YES NO
Date reported
Time reported:
Did the Police visit the scene of the accident? YES NO
Name of police officer:ldentity Noldentity No
Name of police station
Pease advise the current location of the damaged vehicle for inspection purposes and state whether mobile
6. STATEMENT BY DRIVER



STATEMENT BY INSURED	
Draw a sketch stating the approximate measurement(s) showing positions of vehicle(s) and person(e direction in which they were travelling. (include type and position of traffic signs, skid marks, pedery other relevant information where possible).	
ark the damaged areas relating to the accident.	



Name						
Phone number						
• •						
Name of hospital						
Name of doctor:Tel: NoTel: No					•••	
10. THIRD PARTY PROPERTY DAMAGE.						
Name:				•••		
Property Details:				••••		
11. IF THE ACCIDENT INVOLVES A THIRD PARTY VEHICLE, PLEASE INDICATE: Name of Owner:Tel No:Tel No:						
Name of Driver:			•••••	•••		
Physical address:						
Vehicle Reg No:Make.:Make.:						
Name of Insurer:						
Period of insurance						
DECLARATION						
I do hereby to the best of my knowledge and belief, warrant the truth of the foregoing state that if I have made any false or fraudulent statement, the policy shall be cancelled and claim			very r	espe	ct and	agree
I agree to provide additional information to the company if required.						
Name of Insured :	ite:					
FIRE, BURGLARY, MONEY, ALL RIS CLAIM FORM						
FOR OFFICE USE						
Claim number						
1	1	1		ı		
Policy No Class						
THE INSURED						
		1	1	1		
THE INSURED Title Name of Company						
Title Name of Company or Surname	1					
Title						

Madam Pesa Pata bima haraka					
Plot No Street, Road, Avenue, etc					
Continued					
Occupation or profession	Ш				
Daytime telephone contact Code Number					
Situation or premises or place where loss or damage occurred					
Date of loss or damage Time Time Explain fully how the loss damage occurred					
When was the loss or damage discovered? Date					
By whom was the discovery made?					
When was the property last seen? Date Time By w					
When were the police notified? Address of police					
Vho notified the police? Address Address Address Address					
Have any other steps been taken to recover the property?					
LEASE ANSWER THE FOLLOWING QUESTIONS IF THE CLAIM IN RESPECT OF A THEFT AT YOUR OWN PI	iEMISE:				
otal value of contents of premises at time of theft Tshs					
Are the premises, or any part, let or sublet?					
How many nights have the premises been unoccupied during the past year?					

In respect of damage to building or landlord's fixtures (including decorations) are you responsible for the repair of such damage under the terms of a tenancy agreement...

Was anyone in the premises at the time of theft?

Have you ever sustained a loss or claimed against any insurer for any of the risks included

If so, please give names and address



Was there at the time of the occurrence any other existing insurance effected by you or any
other persons on the property for which this claim is made. If so, please give
details

PARTICULARS OF THE CLAIM TO BE GIVEN IN DETAIL

In respect of building claims, tradesmen's estimates should be furnished before instructions are given for the work to be put in hand. If decorations are involved, please indicate when they were last renewed.

Any damaged property should not be disposed of until permission is given by the Company.

1	2	3	4	5	6	
Particulars of each building or article in respect of which this claim is made	Date purchased or received	Name and address of person from whom article was purchased or by whom presented	Original cos price	Value at the time of the loss after allowing for age and wear	Amount claimed a allowing value of t salvage	for
			Tshs	Tshs	Tshs	
Total amount claimed						

c) Personal Accident

Policy No			
Name of Insured			
Address			
Designation			
Type of work (describe duties in full)			
Basic salary/earnings (per annum): Place of Accident		Date of accident Time	
1 How did the accident occur?			
2 What were you doing?			
3 Was it fatal?	Yes	No If not fatal, w apparent inju	
Head			



	Arm						
	Legs						
	Trunk						
	Hips						
	Hand						
	Ribs		T				
Hav	ve the above part(s) been injured previously		Yes		No		
5	How long have you been totally Disabled/partially disabled?						
			Г			Т	
6	Have you now resumed you employment/ Duties? When?		Yes		No		
7	How long have you been bed Ridden?						
8	How long have you been confined to your house? To which hospital were you admitted?						
10	Were you operated on?	Yes		No			
11	Name and address of doctor who operated on you:						
12	Is he your usual doctor?	Yes		N	lo		
13	Name and address of doctor treating you:						
	ve you undergone medical or surgical atment during the past five years?	Yes		No			
If y	es, give particulars:						
14	Name and address of any witnesses						
15	Are you insured for personal accident with any other company?	Yes		No			
If y	es, give name/address of branch						
16	Do you hold a life policy?						



If yes, give name and address of insuring company

ess of insuring

d) Fidelity Guarantee

a) Fi	denty (Juaran	tee			
			form does not confirm adr Limited	mission of	liabilit	y on the part of
Name	of Insu	ıred:				
Full a	ddress.					
Telep	hone N	o(s)		Fax No	(s)	
Busin	ess					
Policy	[,] No					
1. 2. 3.	Name (i) (ii) What	(s) and Name Positio Name Positio	Position(s) of defaulting en	nployee(s)	ts?
4.	(a) (b)	Have p If yes; (i) (ii) (iii)	Name of Police station Date of notification Who notified Police			Yes/No
5. 6. 7.		is estim Give fu	during which the default too ated amount of loss? all details of how this amou en calculated; (Attach a so	nt :		
	(b) Ha	By Aco	unt of loss been certified countants or Auditors? attach the Accountants/rs report.		b)	Yes/No



8. (a)

_	(b)	If Yes, give details	b)							
9.	Give for	ull description of the circumstances	3							
	of the loss and how it was discovered.									
	(Attach report if space available is not enough)									
10	`	methods were used to conceal the	O ,							
11	1. What i	measures have you taken to preve	ent recurrence?							
	2. (a)	Have any monies due to the								
	()	defaulter(s)								
		been withheld?	a) Yes/No							
	(b)	If yes, provide details	b) Salary							
	(5)	n yee, previde detaile	Pension/							
			Gratuity							
			Leave pay							
			Other							
			Total							
11	2 (a)	Do you hold any other guarantee	TOlai							
12	2. (a)	Do you hold any other guarantee	۵۱	Yes/No						
	/I- \	Or Security for the employee(s)	a)	Y es/INO						
	(b)	If yes, give details	b)							
e) Public Liability The issue of this form does not imply admission of liability on the part of this company. All questions must answered fully – ticks and dashes are not acceptable.										
Nam	ne of the	Insured :								
Full	Address	Full Address								
Telephone No: Email address:										
Tele	phone N									
	•	lo: Email a	address:							
Busi	iness or	lo: Email a	address:							
Busi	iness or	lo: Email a	address:							
Busi Polid	iness or	No: Email a	address:							
Busi Polic	iness or by No: (a) Whe	Occupation:email a	1. (a)							
Busi Polid	iness or by No: (a) Whe	Occupation : en did the accident occur re did the accident occur	1. (a) (b)							
Busi Polid	(a) Whe	Occupation : en did the accident occur re did the accident occur ain fully how the accident	1. (a)							
Polid	(a) Whe	Occupation :	1. (a) (b) (c)							
1. ((2. ((a) Whe	Occupation : en did the accident occur re did the accident occur ain fully how the accident	1. (a) (b)							

a)

Yes/No

Have the defaulters been involved in or been suspected of any previous loss?



3.	(a) (b)	was the accident reported to Police If yes,	3. (a)
	(-)	(i) Name the Police Station (ii) Give the date reported	(b) (i)
		(iii) Name the person who reported to Police	(ii) (iii)
4.	(a)	Were person injured? If yes, provide full details on page 2	(a) Yes /No
5.	(a)	Was any property damaged? If yes provide full details on schedule "A" below	(b) Yes/No
6.	(a) (b)	Have you received notice of a claim If yes, provide full details and attach to this form any correspondence received	(a) Yes/No (b)
7.	(a) (b)	Have you admitted liability? Do you think you are legally liable?	(a) Yes/No
			(b) Yes/No
8.	(a)	Are there any other insurances covering this accident?	(a) Yes/No
	(b)	If yes, give name of the Insurance Company	(b)

ANNEXURE II

CHECK LISTS

a) Motor

INSURED

- i) COMPLETED CLAIM FORM
- ii) ORIGINAL ADMISSION OF GUILT RECEIPT
- iii) POLICE REPORT
- iv) COPY OF DRIVER 'S LICENCE
- v) PREMUIM PAYMENT RECEIPT
- vi) COPY OF MOTOR CERTIFICATE
- vii) COPY OF CERTIFICATE OF INSURANCE
- viii) QUOTATIONS FROM APPROVED GARAGES
- ix) INSPECTION OF MOTOR VEHICLE

THIRD PARTIES

- x) COPY OF DRIVER 'S LICENCE
- xi) INSPECTION OF VEHICLE
- xii) COPY OF MOTOR INSURANCE
- xiii) COPY OF REGISTRATION CARD
- xiv) QUOTATIONS FROM GARAGE



THIRD PARTY INJURIES

- i) Letter requesting compensation
- ii) NRC
- iii) Medical Certificate
- iv) Medical receipts
- v) Proof of Income if any

b) All Risks

c) Fire

d) Fidelity Guarantee

- I CLAIM FORM
- i) CONTRACT OF EMPLOYMENT
- ii) TERMINAL BENEFITS
- iii) SYSTEM OF CHECK
- iv) POLICE REPORT
- v) DISMISAL LETTER
- vi) PROOF OF PROSECUTION
- vii) PROOF OF CONVICTION
- viii) REFERENCE LETTER FROM PREVIOUS EMPLOYER

ANY OTHER DOCUMENTS MAY BE REQUESTED AS NEEDED.

e) Personal Accident

INJURIES

- i) Full Personal Accident Claim form inclusive of Medical Certificate
- ii) Police report in respect of RTA
- iii) Pay slips for three months before accident
- iv) Letter from the Human resource stating the period when employee was off work
- v) Copy of employees

DEATH

- i) Claim Form without Medical certificate
- ii) Police report in respect of RTA
- iii) Pay slips for three months prior to death
- iv) Death Certificate
- v) Burial permit
- Vi) Confirmation of death from Human Resource