



Your Trusted Risk Manager

# সেনা ইন্স্যুরেন্স পিএলসি

## Sena Insurance PLC

(A Concern of Sena Kalyan Sangstha)

Corporate Office: SKS Tower (12<sup>th</sup> Floor), 7 VIP Road, Mohakhali, Dhaka-1206  
PABX:+8802-9885604, 9885606  
Fax: +88-02-9885631  
E-mail: [claimskicl@gmail.com](mailto:claimskicl@gmail.com)  
[info@senakalyanicl.com](mailto:info@senakalyanicl.com)  
Web: [www.senakalyanicl.com](http://www.senakalyanicl.com)

### PERSONAL ACCIDENT CLAIM FORM

#### CLAIM NO.

This form should be completed and returned within seven days of its receipt by the Insured.

#### PARTICULARS OF CLAIM

Name of Insured (In full): \_\_\_\_\_

Private Address in full \_\_\_\_\_

Business Address \_\_\_\_\_

Profession or Occupation: \_\_\_\_\_ Present age \_\_\_\_\_ Years \_\_\_\_\_

Policy No: \_\_\_\_\_ Date of payment of last premium \_\_\_\_\_

1. State when and where the accident took place Date \_\_\_\_\_

Time \_\_\_\_\_

Place \_\_\_\_\_

2. State how it happened and what you are doing at the time. \_\_\_\_\_  
(If is necessary that the fullest details be give)

3. State (a) what injuries you have sustained \_\_\_\_\_

(b) Whether you have ever had an injury to the same part before \_\_\_\_\_

4. Are you Insured elsewhere against Accidents? \_\_\_\_\_

If so, give particulars \_\_\_\_\_

5. Give the Name and Address of any witness of the accident \_\_\_\_\_

6. Give the name and address of the Medical Man who attended you on your meeting with the accident \_\_\_\_\_

Is he your usual Medical Attendant? \_\_\_\_\_

Has he or any other Medical Man attended you during the last five years for any illness or injury? \_\_\_\_\_

If so give particulars \_\_\_\_\_

7. Have you as the direct result of the accident been totally incapacitated from attending to business of any kind?  
If so state for how long From \_\_\_\_\_ To \_\_\_\_\_
8. Are you still totally incapable of attending to business of any kind? From \_\_\_\_\_ To \_\_\_\_\_
9. State if (a) Confined to bed  
(b) Confined to house  
(c) Able to get out of doors
10. If now able to attend to any portion whatever of your business or occupation, state when you commenced to do so. \_\_\_\_\_
11. Have you fully resumed your usual business or occupation?  
If so since when. \_\_\_\_\_
12. When and where can you be visited by our Medical or other Officer? \_\_\_\_\_  
Name nearest Railways Station & distance there from
13. If you are prepared to agree to an immediate settlement please state the amount you are willing to accept. \_\_\_\_\_

I, the undersigned, do hereby declare that to the best of my knowledge and belief the foregoing particulars are true and correct.

Date:

Signature of the Employee/Nominee

No claim can be entertained without the certificate of a dully qualified and registered medical practitioner.

**MEDICAL CERTIFICATE**

1. Name of claimant \_\_\_\_\_
2. So far as you aware, how did the injury arise? \_\_\_\_\_
3. When did the first consult you in connection with the accident? \_\_\_\_\_
4. Are you still in attendance? \_\_\_\_\_
5. Are you the usual Medical Attendant?  
If so, how long have you known to him? \_\_\_\_\_
6. Please state fully the nature of the injuries sustained.  
(If it is a limp or eye injured state whether right or left) \_\_\_\_\_
7. Are the symptoms from which he suffers due to the accident alone?
8. Is the claimant suffering from any disease in addition to the  
present injuries or has he any physical defect? \_\_\_\_\_  
If so, state the nature of same and to what extent the recovery may  
be affected there.
9. State if the Claimant by your advice is  
(a) Confined to bed \_\_\_\_\_  
(b) Confined to house \_\_\_\_\_  
(c) Able to get out of doors \_\_\_\_\_
10. If the Claimant is in your opinion unable to give any  
attention to his profession or occupation, as described \_\_\_\_\_  
on the front page please state:  
Date of commencement of total disablement, Probable future duration.
11. In the event of the Claimant being able to give partial attention  
to such profession or occupation please state: \_\_\_\_\_  
Date of commencement of total disablement, Probable future duration.
12. If recovered please state date of recovery \_\_\_\_\_
13. General remarks \_\_\_\_\_

I CERTIFY that do the best of my belief the foregoing statements are correct.

Signature:

Address: