Sagarmatha Lumbini Insurance Co. Ltd.
Post Box 12211, Kathmandu, Nepal.
Tel: 4511707, 4512367, P.O. Box: 12211
Email: claims@salico.com.np/www.salico.com.np

GROUP PERSONAL ACCIDENT (GPA) /PERSONAL ACCIDENT (PA) CLAIM FORM

Policy No. ……..… Claim No. …….…….

This form is issued without admission of liability and must be completed and returned within seven-day receipt. No claim can be admitted unless the MEDICAL CERTIFICATE OVERLEAF is furnished.

INSURED DETAILS:

1. Insured Name : .....

   Address : .....Tel. No….....

EMPLOYEE DETAILS:

2. Name : .....Age: .....

   Home Address : .....Mobile No: ……...

   Occupation : .....Monthly Earnings Rs: .....

The average weekly amount paid by the Insured to the Employee during the twelve months preceding the accident or during any shorter period of employment.

3.	(a) Date and Time of Accident:	
	(b) Place of Accident/Where did it occur?	
	(c) Cause of Accident/Details of accident:	
	(d) Injuries Sustained:	
4.	Name and Address of Witnesses:	
5.	(a) Name and Address of doctor who attended employee:	
	(b) Name and Address of employee's ordinary medical attendant:	
6.	(a) Period during which employee has been totally disabled for work as the sole and direct result of the accident.	
	(b) Is employee still disabled? If so, when does he expect to return to work?	

I / We HEREBY DECLARE that the above-named employee received the above described injuries and that to the best of my / our knowledge the foregoing particulars are in every respect true.

Date: Signature:
.....

MEDICAL CERTIFICATE TO BE COMPLETED BY EMPLOYEE'S DOCTOR

I CERTIFY that Mr./Miss.....

was injured on .....

His injuries are .....

If his injuries are complicated by any other conditions, give details

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He is totally disabled and will be so disabled until:

Signature and

Qualifications

Date: .....

Total Disablement occurs when the Employee is wholly prevented from attending to his business or occupation.