HIMALAYAN Everest INSURANCE CO. LTD.
Babarmahal GPO Box - 148, Kathmandu, Nepal
Tel: 5245090,5245091

PERSONAL ACCIDENT CLAIM FORM

1. Insured's Name & Full Address : _____

   with Telephone No. : _____

2. Name of the Injured Person : _____

3. His/Her Residence Address : _____ Tel. No. : _____

4. Policy No. : _____ Period of Insurance : From : _____To : _____

5. Date of accident:_____ Time: _____ Place of accident : _____

6. Full details how accident occurred : _____

   _____

   _____

   _____

7. Name & Address of the witness : _____

8. Name, Qualification & Address of : _____

   attending doctor/surgeon _____

9. Period of complete confinement to **bed/room/hospital** : From : _____ To : _____

10. Period of complete confinement to **house only.** : From : _____ To: _____

11. If any part of your business work is attended by the injured person in respect of (11) above. Give details : _____

    _____

12. Details of compensation, if any, paid to him/her during confinement period : _____

    _____

13. Please specify monthly salary of the injured person : _____

    _____

14. If you are insured elsewhere, please enclose policy copy. : _____

    _____

15. Do you wish to add any additional information? If so, Please give details. : _____

I/We declare that the above statements are true to the best of my/our knowledge.

Date: .....

Signature of Insured with Official Seal / Stamp

MEDICAL REPORT

(To be completed by the attending doctor)

1) Name of the injured Person : _____

   Age: _____ Sex: _____

2) Date of Accident : _____

3) Cause of accident : _____

   _____

4) Extent of injuries sustained : _____

   _____

   _____

   _____

   _____

5) Date of your first attendance : _____

6) Are you his/her usual Medical Attendant?: _____

7) Is the injury due to direct result of accident? If not, please give details _____

8) Period required for complete recovery in respected of :-

   a) Complete confinement to **Bed/Room/Hospital** : From: _____ To: _____

   b) Confinement to **House** only : From: _____ To: _____

9) Details of Permanent Disability, if any, remains with the injured person as a result of the accident : _____

   _____

   _____

10) Further remarks, if any _____

    _____

11) Is the Injury, was under the influence of alcohol or drugs at the time of accident? _____

    _____

I hereby certify that the foregoing statements are true and correct to the best of my knowledge.

Signature: _____ Medical Qualification: _____

Full Name in Block Letter: _____ NMC No.: _____

Full Address with Official Stamp, if any _____