



Orient Business Claim Form

**NOTE: All Questions on this form must be answered.
The company does not admit liability by issue of this form.**

POLICY HOLDERS DETAILS

- 1 Full Name |
- 2 Telephone No. |
- 3 Postal Address / Postal Code / Town |
- 4 Email |
- 5 Business Occupation |
- 6 Policy No. |

PROPERTY

- 1 Are you the sole owner of property insured? | YES [] NO []
- 2 If No give name and address of the owner(s) |
- 3 Are there any other insurances on the property insured? | YES [] NO []
- 4 If yes, give name of insurer and policy number |
INSURER |
POLICY No. |
- 5 What was the total value of the contents at the time of loss? |

CIRCUMSTANCES

- 1 Physical address of premises where theft, loss or damage occurred |
- 2 DATE OF LOSS | TIME |
- 3 Give brief details of the circumstance of loss? |
- 4 By whom was loss discovered? |
- 5 Were the premises occupied? | YES [] NO []
- 6 If no, when were they last occupied and by whom? |

PREMISES

- 1 State briefly how entry to premises' was effected? |

2 If not forcible entry, how did loss occur? |

3 State purpose for which premises are occupied |

4 Are you responsible for repairing damages to the premises? | **YES** [] **NO** []

5 If yes, where are you responsible? |

4 Was the property guarded by a watchman/ security firm? | **YES** [] **NO** []

4 Give name and contact of the watchman/security firm? |

NAME |

CONTACT No. |

CLAIM HISTORY

1 Have you had any previous losses by fire, burglary or any other cause? | **YES** [] **NO** []

2 If yes, give particulars, |

PARTICULARS OF CLAIM

Note

The amount of the damage should be stated. Receipts obtained at the time of purchase of the under mentioned articles should be attached, wherever possible, for inspection and subsequent return.

1 Description of property claimed, |

2 When state when and where bought and from whom, (attach valuation for items of jewelley) |

3 Original cost/price Kshs. |

4 Deductions for age use wear & tear Kshs. |

5 Amount claimed Kshs. |

INJURY DETAILS

The Injured Person

1 Name | ID No. |

2 Was the injured person engaged in this occupation when the accident occurred? | **YES** [] **NO** []

3 If not state fully the nature of work he was doing at the time of accident ? |

4 Is the injured person in your direct employ? | **YES** [] **NO** []

5 When did the injured enter your service? |

6 Name the hospital taken to? |

7 State whether still in hospital or when discharged? |

8 Has the injured person been medically examined? | **YES** [] **NO** []

- 8** If YES attach Report? | **YES** [] **NO** []
- 9** Has the injured person returned to work? If so when? |
- 11** Is the injured person able to do partial work? | **YES** [] **NO** []
- 12** What is the probable period of disablement? |

THE ACCIDENT

- 1** DATE |
- 2** TIME |
- 3** PLACE |
- 4** Upon what date did you receive notice of accident? |
- 4** On what date did the injured person actually cease work? |
- 5** State cause of the accident |
- 6** State nature of injury |
- 7** Was the injured person under the influence of drink or drugs at the time of accident? | **YES** [] **NO** []
- 8** Was he/she guilty of any misconduct or disobedience to orders or rules? If so, give full particulars |
- 10** State through whose neglect it occurred, if any? |
- 11** State the names of any person who witnessed the accident? |

THE ACCIDENT

I DECLARE that these particulars are true and correct and undertake to forward immediately all correspondence relating to this accident, unanswered.

Name |

Date |

Signature of Insured (and Stamp)