ENAYA INSURANCE

عنايـــة للتـــأميـــن

CLAIM FORM – GROUP LIFE/PERSONAL ACCIDENT/WORKMEN'S COMPENSATION

Type of Claim	
Death	✔
Injury	✔
Sickness	✔

*** Please tick the above checkbox**

IMPORTANT: Issuance of this form is not to be taken as an admission of liability nor answering these questions implies that the injured person is making or will make a claim. **If any detail of information is not readily available, please do not delay dispatch of this report. Such particulars may be sent later.** ***All written communications should be forwarded to the Company at the address below.***

POLICY NUMBER: **CLAIM NO.:**

THE EMPLOYER/INSURED		
1.	Name of the Policyholder	
2.	Business	
3.	Address Phone Number:	
THE INJURED PERSON		
1.	Name	Age Sex
2.	PF Number	CIVIL ID Number
3.	Local/Permanent Address	
4.	State occupation/nature of work of the person	
5.	Was the person engaged in this occupation when the incident occurred? If not, state exactly the nature of the work he was doing at the time of death/Injury.	
6.	Is the person in your direct employment? If not give name and address of Contractor, under whom employed and nature of work entrusted to contractor.	
7.	When did the person enter your service?(Date of Employment)	
8.	Has the person been medically examined or hospitalized? If so, please send copy of Medical report.	Medical Report Enclosed **Yes** ☐ **No** ☐
THE ACCIDENT		
1.	Date Time	Place
2.	State how this incident occurred	
3.	Date and Time of notice of incident and by whom? If in writing, please attach it to this form.	
4.	In case of Death Time, day and date	

5.	Was the incident reported to Police or Inspector of Labour (A copy of report to be attached)	
6.	Cause of Claim (In case of Death claim)	
7.	Was the person under the influence of alcohol or drugs at the time of incident? If yes, give details.	
THE CLAIM		
1.	Does your claim include reimbursement for medical costs?	**Yes** ☐ **No** ☐
	Claim Amount	
2.	Does your claim include reimbursement for loss of income (sick leave)?	**Yes** ☐ **No** ☐
	Claim Amount	

I declare that to the best of my knowledge and belief these particulars are full and true. I agree to provide any further information that may be required.

Place: Name: _____

Date: Designation: _____

Signature of Policyholder
(Stamp/ Seal of the Company)

Documents to be submitted along with the claim form in case of Injury:

1. Original Disability Certificate from Ministry of Health and Occupational Health Department
2. Initial medical report from the Ministry of Interior (Police report) from the Hospital
3. Sick leave Medical Certificates from the attending doctor
4. Copy of a Valid Civil ID

Documents in case of a death case:

1. A detailed incident report in case of Accidental death
2. Copy of Police report (where applicable)
3. A Certified Copy of the final death certificate and medical report on the onset cause of the death.
4. Original Death Certificate and Medical report on the onset cause of the death should be attested by the ministry of external affairs of the country where the death occurred and subsequently from embassy of Kuwait of the country where death had occurred. (In case death happened outside the Kuwait)
5. Copy of Valid Civil ID.
6. Cancelled Passport copy (If death happened in Kuwait)
7. Repatriation Invoice. (Incase Mortal remains buried outside Kuwait)

- *The above required document is not final and company may ask for additional documents on case to case basis.*

Claim Process:

1. Intimate the claim immediately to the insurer (at the below given contact) with the basics detail such as, policy number, incident date, name of the injured person and type of injury.
2. Obtain claim number from the insurer.
3. Provide the insurer with the above mentioned documentation.
4. Claim number is must while providing any supporting documents of the claim.