Alpha INSURANCE COMPANY LTD.

(INCORPORATED IN PAKISTAN)

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Policy No. ____________

STATEMENT AND PARTICULARS OF PERSONAL ACCIDENT CLAIM

This From is issued without admission of liability, and must be completed and returned within seven days after its receipt. No. claim can be admitted unless a Medical Certificate (attached) be furnished at the expense of the Claimant, and all other terms and conditions of the Policy be strictly complied with.

1. Name in full ____________ Present Age ________ Years
   Address ____________ Height ______ Ft ______ In
   ____________ Weight ________ Kgs.
   Present Business or Occupation ____________ If more than one state all ____
   If away from home state where now staying and when expacted to leave ________

2. Place and date of Accident : The Accidnet occured at
   on ________ the ________ day of ________ 19 at a.m/p.m.

3. Describe as fully as you can how the Accident happened, and what you were doing at the time ________

4. Describe the nature and extent of the Injuries you have received.

5. Give the name, Occupation, and Address of a witness of the Accident ________
   Name ____________
   Occupation ____________
   Address

6. Have you followed any occupation other than that stated in your policy? If so, what was its nature.

7. Have you previously clamied or received compensation under an Accident and/or sickness policy? If so give particulars.

8. (a) Are you insured elsewhere ? (a) ____________
   (b) If so (i) give the name of each Company and (ii) amount you are entitled to claim (b) (i) ____________
   ____
   (ii) ____________

9. On what date was your last premium paid ?

10. State the extent and duration of your total inability to attend to your business or occupation.
    I have been Disabled Wholly for ______ days, from ____________ to ____________
    I am now (Insert "wholy", or "not at all", as the case may be) ____________ disable.
    If still wholly disabled state how much longer this total disability is likely to continue ____________
    ____

11. Have you since the accident presonally directed or supervised or given any attention whatever to any part or your business or occupation? If so, give full particulars and dates

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12. (a) Name and Residence of the Doctor who attend you for the said Injuries (a) ______________________

(b) Is the your usual Medical Attendant? If not, why? (b) ______________________

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13. Are you perfectly free from any physical Defect, Infirmity or Disease? ______________

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14. Are you at the present time able to state the amount for which you are willing to settle the claim?

(The Compensation is based upon the actual period of total disablement)

I hereby declare that I have received the Accident Injuries before described, by material and external agency, and do therefore claim compensation under Policy No. ______________ in respect thereof, and I do further declare that I am and always have been uniformly sober and temperate in my habits, and that I was in no way under the influence of intorxicating, liquor nor exposing myself to obvious or unnecesary danger or peril, when the accident occoured, that I have not abstained entirely from my usual occupation longer than absolutely necessary in consequence of the said Injuries, and that such Injuries are the sole cause of my total disablement. I do hereby warrant the truth of the foregoing statement, particulars, and declaration in every respect: and I agree that if I have made, or in any futher declaration the Company may require of me in respect of the said Accident, shall make any false or fraudulent statement or suppress, or conceal any material fact, the Policy shall be viod as against the Company and my right to compensation absolutely forfeited: and I am willing, whenever required by the Company to make a solemn declaration before a Justice of Peace of the truth of all the foregoing statements, and of such other particulars as may be reasonably required by the Company.

Witness:

____

(Signature of the Claimants)

Address ______________________

Date ______________________