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Lion Insurance Company (S.C.)

(UNDER FORMATION)

NATIFCATIONS OF CLAIM FOR ACCIDENT AND DISEASES

TO BE FILLED BY THE EMPLOYER

THIS FORM MUST BE COMPLETED AND RETURED WITHIN SEVEN DAYS OF THE ACCIDENT OR DIESEASE.

Employer _____ Town _____ Tel. No. _____
Address P.O. Box _____ K/Ketema _____ Kebele _____
Activity _____ Policy No. _____
Name of the injured person (in full) _____
Date of Birth _____
Category of work _____ Registration No. _____
In the insured's service from _____
Date of the accident _____ Place of the accident _____
When was the Employer informed of the accident? _____
Brief description of the accident _____
_____
_____
Daily wage Birr _____
Monthly Salary Birr _____

Witnesses **The Employer**

_____ _____
_____
_____ _____

LION INSURANCE COMPANY S.C. **Detachable Slip for Hospital File No.** _____

To:_____Hospital _____
Patient's Name (in full) _____
Employer's Name _____ Address _____
You are kindly requested to assist the bearer of this from and offer him/her medical treatment and/or hospitalization if necessary. Your bill will be settled upon presentation.

N.B This form is valid only when it bears the Employer's seal and signature, and may only be used to authorize treatment and authorization and/or hospitalization in the case of accident or occupational disease.
please attach a copy of this slip with your bill.

_____
Date _____ **Employer's**

LION INSUREANCE COMPANY (S.C.) **TO BE FILLED BY THE MEDICAL DOCTOR**

D's Name _____
Hospital_____
Patient's Name _____
Type of Injury/disease _____
_____
Treatment prescribed _____
(Please write in words)
Sick Leave _____
_____
Does the patient suffer from any other defect or disease?
Date _____ **Signature** _____