ናይል ኢንሹራንስ ኩባንያ (አ. ማ.)
NILE INSURANCE COMPANY (S.C)

ካፒታል ብር Capital Birr 73,828,000 (በሙሉ የተከፈለ) (Fully Paid-up)

Head office	Main Br.	Life Br	Kirkos Br.	Tewodros Br.	A/Ketema Br.	Bekilo b\Br.	Gerji Br.	Kaliti Br.	Abakoran Br.	Bole Br.	Megenagna Br.	Gotera Br.
☎011-4426000	011-551 4365	011-551 4329	011-5539402	011-1552585	011-2756389/90	011-4655262	011-6298031	011-4400961	011-2779567	011-5546702	011-6188464	0114-426013
011-4425837	011-554 6749	011-554 6749	011-5531715	011-1559967	011-2772155	011-4655289	011-6298032	011-4400962	011-2779568	011-5526907	011-6510977	0114-426000
Fax 011-4426008	011-551 4592	011-551 4592	011-5531716	011-1559968	011-2772058	011-4655308	011-6294564	011-4400963	011-2779797	011-5526908	011-6635607	0114-426008

P.O.BOX 12836 A.A Ethiopia

Bahir Dar Br.	Adama Br.	Awassa Br.	Dire Dawa Br.	Jima Br.	Mekele Br.	Gondar Br.	Dilla Br.	Desse Br.	Debre markos Br.
☎ 058-2201646	022-1114427	046-2201262	025-1110840	047-1114577	034-4408485	058-1119868	046-3312497	033-1120879	058-7716907
058-2203662	022-1114428	046-2204032	025-1129073	047-1114588	034-4406499	058-1119880	046-3312498	033-1113731	058-7716873
Fax 058-2201783	022-1120348		025-1111780	047-1114578				033-1120878	058-7711921
✉ 999	358	529	419	1327	540	90	235	1076	485

NOTIFICATION OF CLAIM FOR ACCIDENTS AND DISEASES

Claim No._____

TO BE FILLED BY THE EMPLOYER

THIS FORM MUST BE COMPLETED AND RETURNED WITHIN SEVEN DAYS OF THE ACCIDENT OR DISEASE

Employer _____ Town_____ Tel. No._____
Address P.O.BOX_____ Woreda _____ 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

_____
_____

NILE INSURANCE Co.(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 form 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/or hospitalization in case of accident or occupational disease.

Please attach a copy of this slip with your ill.

_____
Employer's Signature

Date _____

NILE INSURANCE Co. (S.C.) **TO BE FILLED BY THE MEDICAL DOCTOR**

Dr'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 _____**

Asikale printers