

PERSONAL ACCIDENT CLAIM FORM

Account No.																				
Policy No.																				

VAT No.

Branch or Agency Claim No.

This form is issued without admission Liability, and must be completed and returned within seven days after its receipt. No Claim can be admitted unless the MEDICAL CERTIFICATE OVERLEAF be furnished at the expense of the Claimant.

1. Name in Full

Present Age Height ft. in. Weight lbs.

Residence Tel No.

Email Address Cell No.

Business Address

Present Address or Occupation.....

(If more than one. state all.)

<p>2. (a) When did accident occur? State day and hour.</p> <p>(b) Where did it occur?</p> <p>(c) Give full particulars of the cause and the injuries sustained</p>	
<p>3. Give names and address of any witnesses of the accident</p>	
<p>4. (a) Give name and address of Doctor who attended you</p> <p>(b) Name and address of your ordinary General Practitioner</p>	
<p>5. (a) State where and when a Medical or other Officer of the Company can visit you, if necessary</p>	
<p>6. (a) State this period during which you have been totally disabled from attending to your business as the sole and direct result of the accident</p> <p>(b) Are you still totally disabled? If not, from what date were you able to attend to some part of your business?</p>	<p>from 20</p> <p>to 20</p> <p>from 20</p> <p>to 20</p>
<p>7. (a) Have you previously received compensation under an Accident and/or Sickness Policy? If so, please give particulars</p>	
<p>8. (a) Are you insured elsewhere? (b) If so, give the name of each Company or Insurer, and amount you are entitled to claim</p>	

I HEREBY DECLARE that I have received the injuries above described, and warrant truth of the foregoing particulars in every respect, and I agree that if I have made if I shall make, any false or untrue statement, suppression or concealment my right to compensation shall be absolutely forfeited.

Date20 Signature

PRIVATE AND CONFIDENTIAL

TO BE COMPLETED AND SIGNED BY THE INSURED PERSON'S MEDICAL TREATMENT

Name of patient Age

Profession or Occupation

Are you the Patient's usual Doctor? Period known to you

Cause of incapacity

Date Patient first seen

State nature and extent of injuries

Disablement	From	To	Prognosis (Please indicate probable duration of disablement)
Confined to house			
Unable to give attention to any occupation			
Able to give some attention to this occupation			

If Patient has now fully recovered, date of recovery

Dates and details of injuries from which he has previously suffered

I hereby certify having personally examined the above-mentioned Patient, that in my opinion the disability arises solely as a result of the accident described and that there are no other circumstances tending to produce either total or partial disability except

Signed Qualifications

Address Date

The Fee (if any) for this Certificate to be paid by the Claimant