MASSY UNITED INSURANCE

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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.) .....

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

I HEREBY DECLARE that I have received the injuries above described, and warrant truth of the foregoing particulars in every respect, and I agee 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.

Date .....20..... Signature .....


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