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.) ....

Question	Answer
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 ....

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