

PERSONAL ACCIDENT CLAIM FORM PLEASE STATE AS FULLY AND AS ACCURATELY AS POSSIBLE THE INFORMATION ASKED FOR BELOW. ACCEPTANCE OF THIS FORM IS NOT AN ADMISSION OF LIABILITY N.B. BOTH CLAIM FORM AND DOCTOR'S CERTIFICATE TO BE COMPLETED AND RETURNED IMMEDIATELY

INSURI	ED:	Name			Address							
Telephone No.		Home										
*SHOULD THE COMPANY BE LIABLE TO SETTLE THIS CLAIM PLEASE TICK THE APPLICABLE												
1. DEPOS	IT CHEQU	E INTO: BANK		ACCOUN	IT NO	BRANCH						
2. SEND CHEQUE VIA MY BROKERS												
	1.	The Accident. Date		Time	Plac	e						
Description of Accident												
2.	Names & A	Addresses of Witnesses										
3.	Particulars	of injuries										
4.	Name and address of doctor in attendance											
5.	How long have you been totally or partially disabled from work as a result of your injuries?											
	Totally Fr	rom	То	Partiall	y From	То						
6.	How long	have you been confined	to:									
		Hospital?	From		То							
		House?	From		То							
7.	When do you expect to be fit to resume your occupation?											
8.	Are you cla	aiming under any other	insurance?	YES	NO	If YES please give particulars						
Date:				Signature of Insured								

If the Insured is unable to attend to this form, it should be completed on his behalf.

MEDICAL REPORT AND CERTIFICATE

I DO HEREBY CERTIFY THAT THE WITHIN NAMED PARTY HAS RECEIVED FROM EXTERNAL VIOLENCE ,THE FOLLOWING ACCIDENTAL INJURIES:-

ions Injured, If b, State Right or		Fracture	Dislocation	Cuts or Tears	Contusion or Crushing	Sprains	Nature And Extent Of Injuries					
1.	Name of	patient	,									
2.	When did he first consult you about this accident?											
3.	Are you still in attendance?											
4. Are you his usual doctor?												
5.	State natu	are of injury and h	ow sustained									
6. Is his condition due solely to the accident? YES NO If so give details												
7.	Please sta	ate whether his cor	al infirmity									
8.	Is he totally incapacitated from attending to any part of his occupation?											
	(a) Date of commencement											
	(b)	Probable durat	ion from date of this certi	ficate								
	(c) If total incapacity has ceased, date of cessation											
9.	If he is only partially incapacitated in the sense that he is unable to attend to a substantial and essential part of his occupation?											
	(a) Date of commencement											
	(b) Probable duration from date of this certificate											
	(c)	If partial incap	eacity has ceased, date of	cessation								
10.	Is he/she	on your advice co	nfined to the house or hos	pital?								
11.	General r	emarks:										
11.	Generari	cinarks.										
Signature				Qualificat	ions							
	a. ·											
(+ Official	Stamp)		Address									