



PERSONAL ACCIDENT CLAIM FORM

This form is issued without admission of liability, and must be completed and returned within seven (7) days after its receipt. No claim can be admitted unless the **MEDICAL CERTIFICATE OVERLEAF** be furnished at the expense of the Claimant.

Policy No.
 Name of insured person Age Weight Height
 Residential address Tel
 Business address Tel
 Present Business or Occupation
 (If more than one, stage all)

1. (a) When did accident occur? State day, date, and hour. (b) Where did it occur? (c) Give full particulars of the cause, and the injuries sustained.	(a) (b) (c)
2. Give names and addresses of any Witness of the accident.	
3. (a) Give name and address of the Doctor who attend you. (b) Name and address of your ordinary Medical Attendant.	(a) (b)
4. State where and when a Medical or other Officer of the Company can visit you, if necessary.	
5. (a) State the 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?	(a) (b) from to
6. Have you previously claimed or received compensation under an Accident and/ or Sickness Policy? If so, please give particulars.	
7. (a) Are you insured elsewhere? (b) If so, give the name of each Company or Insurer, and amount you are entitled to claim.	(a) (b)

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

Date: Signature:

PRIVATE AND CONFIDENTIAL

MEDICAL CERTIFICATE TO BE COMPLETED BY DOCTOR OF INSURED PERSON.

I CERTIFY the

was injured on

His/ Her injuries are

If his/ her injuries are complicated by any other conditions, give details

He/ She is totally/ partially disabled and will be so disabled until

Date:

Signature Chop and Qualifications