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Personal Accident Claim Form

(If unable to reply personally, this form may be filled in on behalf of the Claimant)

"To avoid delay and unnecessary correspondence in the processing of your claim please observe the following requirements: -
1. Ensure that both the claim form and the medical certificate are Properly completed:
2. Supporting documents or copies thereof plus original medical bills incurred, if any, must be submitted with the claim form."

Insured's Name:

Claimant' name (in full)_____
_

Address_____
_____

Present Occupation of Claimant_____ Present Age_____

Policy No._____ Date of payment of last Premium_____

1. (a) Date and time of Accident

(b) Place of Accident

(c) Describe fully how the accident happened_____

_____
_____

(d) Give name, occupation and address of a witness of the accident, if any:

Name_____

Occupation_____

Address_____

_____

2. (a) Describe the nature and extent of the injuries you have received_____

_____

(b) Name and address of hospital where you went for treatment

Name

_____

Address

(c) Give names and addresses of the Doctors who have attended you for these injuries at the hospital

Name

_____

Address_____

_____

3. (a) State the number of days you have been ENTIRELY confined to your Bed, Room or House:-

(i). Number of days confined to bed_____days,

from_____

to_____

(iii). Number of days confined to house_____days

from_____to_____

(ii). Number of days confined to room_____days,

from_____to_____

_____

(b) If you are still confined to your Bed or Room or House, state which_____

4. (a) State the extent and duration of your Inability to attend to your business or occupation

i. Partially disabled for_____days

from_____to_____

_____

ii. Totally (wholly) disabled for_____days

from_____to_____

I am now _____disabled

(Insert **"wholly",** "**partially**, or "not at all")

5. Have you since the accident personally directed or supervised or given any attention whatever to any part of your business or occupation? If so, give full particulars and dates.

6. (a) Are you entitled to receive compensation from any other company or other source?

If so, give full particulars._____

_____

_____

(b) Have you ever-claimed compensation from any company? Yes_____/No_____

If so, give full particulars._____

___

7. Are you perfectly free from any Physical Defect, Infirmity or Disease? Yes_____/No_____.

If No state nature of infirmity_____

_____

_____

8. Are you at the present time able to state the amount for which you are willing to settle the claim?

(The compensation is based upon the actual period of disablement.)

DECLARATION

I, the undersigned, hereby declare that I am the person referred to in the above statement, which is true in every respect,

And is made without reservations.

I hereby authorize the company to apply to my Medical Attendant mentioned above, for a Report to be furnished at my expense in the form used by the Company for the purpose

Date_____Signed_____

_____

NOTE: The Medical Certificate must be completed by your Doctor before this Claim Form is forwarded to the Company

MEDICAL CERTIFICATE

In order to establish his Claim, the Claimant must obtain and forward to the Company a certificate from a duly qualified and registered Medical Practitioner, and it is essential that this form be filled up as minutely as possible so that the Medical Officer of the Company may properly understand the nature of the case.

To be completed by the Medical Attendant.

1. The Name and Occupation of the Claimant:

2. The exact nature and extent of the Injuries caused by the accident. If a Hand or an arm, a Foot or a Leg. State whether it is the RIGHT or LEFT.

A. Region Injured _____

B. Nature and extent of injury_____

_____

_____

3. Whether the Claimant has suffered or is now suffering from any constitutional or local disease or Physical infirmity. If so, state the nature of such disease or infirmity and to what extent it affects the disablement.

_____

_____

_____

_____

4. (a) When and where did you first attended the Claimant?

At_____

Date_____

(b) Are you still attending him?_____

5. To what extent the above accidental injuries have necessarily disabled the Claimant from giving attention to business.	Claimant has been disabled TOTALLY For_____days	Claimant is now_____disabled • Insert ***totally, partially*** *or* ***not at all*** as the case may be.	The further disability (if any) will in my opinion continue. Totally for_____days Partially for_____days, from the present time.

NOTE

Total Disablement arises when the Claimant is rendered **completely incapable** of attending to any part of his/her ordinary professions, business or occupation**. Partial Disablement** arises when the Claimant is a **little injured**, or has so far recovered from injuries as to be capable of attending to **some portion** of his ordinary profession, business or occupation.

7. (a) Is the Claimant now, in any way, attending to business?
_____

On what day did he first commence doing so after the accident?_____

_____
_____

(b) If not whether you consider Claimant fit personally to supervise or direct his Business or Occupation.

_____
_____

7. Have you any reason to think that the Claimant was not perfectly sober at the time of the accident?

_____
_____

8. Is there any information, professional or otherwise that you consider should be known to the company.

_____
_____

REMARKS: If any:

I certify that I have satisfied myself by personal examination that the Claimant has sustained an accident causing injuries as above described.

Signature_____
Qualifications_____

Official Rubber Stamp

Address_____
Date_____

_____