

Personal Accident Claim Form

Name

Insured _____

Employee _____ Age _____ Years _____

Address

Private _____ Tel. No. _____

Business _____ Tel. No. _____

Occupation _____

Salary: Weekly _____ Monthly _____

Policy No. _____ Date of payment of last premium _____

Date of Accident _____ Time _____ a.m. Place _____
 p.m.

2. What injuries have you sustained?	
3. Has the same part been injured previously?	
4. How long have you been totally or partially disabled From engaging in or attending to your usual business as the result of the injuries?	Totally from To Partially from To
5. How long have you been confined to: - Bed? House?	From to From to
6. Name and address of Doctor who is attending you. Is he your usual Doctor?	
7. Have you required medical or surgical treatment during The past five years? If so, give particulars.	
8. Names and addresses of any witnesses of the Accident.	
9. Are you claiming under any other insurance? If so, give particulars.	

I WARRANT that the above statements and particulars are correct and complete.

Date 20 Signature

MEDICAL CERTIFICATE

1. Name of Patient

2. What injuries has the Patient sustained?

3. When were you first consulted?

4. How long has the Patient been totally or partially Disabled from engaging in or attending to usual Business as the result solely of the injuries?

Totally from to

Partially from to

Totally from to

Partially from To

How much longer do you consider such disablement will continue?

5. Has the Patient any disease or any physical defect and if so, of what nature?

To what extent may recovery be affected thereby?

Signature

Qualifications

Affix Stamp

Address

Date 20
