ACCIDENT CLAIM FORM

*** Please note that every question on this claim form must be answered and it is compulsory that the insured sign the form accordingly**

(1) Name of Insured……

Name of the Claimant……..

Age of Claimants next birthday……

Address:…….

Business/Occupation…….

Policy Nos…….

Date of payment of last premium……..

(2) CIRCUMSTANCES

(a) When did the accident occur?

Date……. Time……

(b) Where?……

(c) What was the Insured doing at the time?……

(d) Full description of the accident……

……

……

(e) Was the insured perfectly sober at the time of accident?

(f) Nature and extent of injuries-If to eye, arm or leg state whether right or left?

……

(g) Is insured right or left-handed? ……

(3) INFORMATION RELATING TO MEDICAL ATTENDANCE

(a)Name and address of doctor who first attended the insured after the accident……

……

(a) Name and address of usual Medical Attendant……

……

(4) WITNESSES

Name and addresses of witnesses……..

…….

(5a) Has Insured ever been, or (b) is he at present insured in respect of personal accident/workmen's compensation risks…….……

(b) If so, with whom……

(c) has insured ever made a claim or received any payment under such Insurances? If so, please state amount or amounts and dates.

(1) (a)As a result of this accident has the insured been totally disabled or incapacitated from attending in any way to his usual business or occupation or to business of any kind?

……..

(b)If so, from what date?……

(c)Has he been able to attend to some portion of his usual business or occupation?

……If so, from what date?……

(d) From what other injuries or illness has the insured suffered and when…….

……

I declare the foregoing particulars to be true in every respect, and I hereby leave in the hands of the Company in accordance with the conditions of the Policy the conduct of all claims and litigation arising out of this accident and to which the Policy applies, to deal with, to prosecute and/or settle as they think fit without further reference to me, and I undertake to give all such information and assistance as the company may require.

Signature of insured……Date……20……..

THE COMPANY DOES NOT ADMIT LIABILITY BY THE ISSUE OF THIS FORM