GROUP PERSONAL ACCIDENT CLAIM FORM

CLAIM NO:…… POLICY NO.:……

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

INSURED'S

NAME:……

ADDRESS:……

BUSINESS OR OCCUPATION:……..…… TELEPHONE NO.:……

INJURED EMPLOYEE'S NAME:……..

DESIGNATION:…… AGE:……

DATE OF ACCIDENT:…….. TIME:……..PLACE:……

1. How did the accident happen and what was the employee doing at the time?

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2. Please give the names and addresses of any witnesses of the accident?

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3. What injuries did the employee sustain?

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4. (a) What is the name and address of the doctor attending to the employee?

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(b) Is he your usual doctor?…… ……

5. How long has he/she been temporarily totally disabled?

From …… To: ……

6. Has he/she required medical or surgical treatment during the past five years? If, so, Please give particulars?

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7. (a) Are you claiming under any other policy for this accident?

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(b) If so, please give details

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DECLARATION

We declare that the above answers are true and complete.

DATE:…… INSURED'S SIGNATURE:……..