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: .....

DESIGNATION: ..... AGE: .....

DATE OF LOSS: ..... TIME: ..... PLACE: .....

1. How did the accident happen and what was the injured/deceased 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? (or cause of death)

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

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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:…….