

GROUP PERSONAL ACCIDENT CLAIM FORM

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

This form must be **COMPLETED** and returned **WITHIN THE NEXT SEVEN DAYS OF RECEIPT**, to the office of the company from which the policy was sent.

1. Section 1: General

(a) (i) Policy Number: _____

(i) Name of Insured/ Claimant: _____

(ii) Address: _____

(iii) Date of Birth: _____

(b) (i) Weight: _____ (ii) Stones: _____ (iii) Pounds: _____

(iv) Height: _____ (v) Feet: _____ (vi) Inches: _____

(vii) Present Profession/Occupation (if more than one, state all): _____

(c) If an Employee, provide the details below of Employer:

(i) Name: _____

(II) Address: _____

(iii) Form of Business: _____

2. Section 2: Disability Claim

(a) (i) Give full details of the injuries sustained by the claimant: _____

(ii) When did the accident occur: Date: _____ Time: _____

(iii) Where did it happen: _____

(iv) What was the Claimant doing at the time: _____

(v) Description of the accident: _____

(vi) Name and extent of injuries: _____

(b) (i) Is Claimant right or left handed? _____

(ii) Name and address of Doctor who first attended to Claimant: _____

(iii) Name and address of usual Medical Attendant: _____

(iv) Name and address of witness of the accident: _____

(c) (i) Has Claimant ever been, or is currently insured in respect of personal accident risk?, if so with whom?

Insurance Co	Policy No	Period of Insurance	Amount Insured

(ii) Has claimant ever made a claim or received any payment under such insurance from this company or others? If so, please state amount or amounts and appropriate dates

Insurance Co	Amount	Date of Receipt

(d) (i) As a result of the accident has claimant been totally disabled or incapacitated from attending in any way to his usual business or occupation or to business of any kind? _____

If so, from what date? _____

(ii) Has he been able to do some portion of his usual business or occupation? _____

If so, from what date? _____

(iii) Is he at the present time totally disabled as above? _____

If so, when does he anticipate being able to resume his usual business or occupation?

(iv) Is he at the present time partially disabled? _____

If so, when does he anticipate being able to resume his usual business or occupation?

(v) From what other injuries or illness has claimant suffered from and when? _____

(vi) If immediate settlement is preferred, state amount accepted in full settlement of this claim:

3. Section 3: Death Claim (if applicable)

(a) (i) State the exact cause of Death and any important factors connected therewith _____

(b) The following documents must be provided for this claim to be considered.

NOTE: it is not necessary to have all these documents when submitting the claim. They can be forwarded at a later stage to avoid any unnecessary delays.

(i) Death Certificate

(ii) Post Mortem Report

(iii) Employer's Report for occupational related death

(iv) Police Report relating to the event that led to the death

(v) Copies of any newspaper clipping or eye witness statements that may be available.

(Compensation is not payable weekly but in one sum at terminated of disalement. The company, however, is always willing to consider any proposal the insured cares to make for an immediate and final settlement)

WE declare that the foregoing answers are true and completed and that I/WE hold no other policy indemnifying me/us in respect of this claim. I/WE request you to deal on my/our behalf with third party claims arising herein, in accordance with the terms and conditions of the above mentioned policy, and I/WE authorize you and your solicitors on my/our behalf to make such admissions and settlements and give such consents as you may consider necessary for the disposal of such claims and any litigation arising therefrom.

Date: _____ Insured's Signature: _____

N.B- If this form has to be filled in and signed on behalf of the Claimant, the relationship to the Claimant of the signatory should be stated here _____