Personal Accident Claim Form

Important Note
The insured is required to state as fully and accurately as possible the information asked for below:-

PLEASE USE BLOCK LETTERS

Claim No.:

Insured

Surname:		First name:
Age:	Height:	Weight:
Occupation:		
Address:		

Policy No.:		Date premium paid:	
Date of accident:	Place:		Time:
Details of incident:			
Nature of injury:			

Witness of accident

Surname:	First name:
Address:	

Attending Doctor

Surname:	First name:
Address:	

Is he/she your usual medical attendent?	☐ Yes ☐ No

Extent of disablement	**Dates**	
1. How long have you been confined to bed?	From:	To:
2. How long have you been confined to you house?	From:	To:
3. How long have you been wholly prevented from attending to all administrative and superintending duties?	From:	To:
4. How long have you been wholly prevented from attending to substantial portion of your administrative and superintending duties?	From:	To:
5. Are you now wholly or partially prevented from attending to administrative and superintending duties?	☐ Yes ☐ No	
6	☐ Yes ☐ No	
	Amount of insurance	$
7.	$	
8.	$	

I hereby declare that I am suffering from the accident described and claim compensation under the above policy in respect thereof; I hereby warrant the truth of the foregoing particulars in every respect and declare that the conditions of my insurance have been fully complied with; and that I have abstained from my usual occupation longer than absolutely necessary and agree that if I have made or shall in any further declaration the directors may require of me in respect of the accident, make any false or untrue settlement; suppression or concealment, the policy shall be void, and my right to compensation absolutely forfeited.

Insured name:	Signature:

Witness name:	Signature: