

PERSONAL ACCIDENT CLAIM FORM

Policy NO. P.A.....
Claim No.....

Important Notice:- The issue of this form is not to be taken as an admission of liability.

FORM TO BE COMPLETED BY THE INSURED.

1. (a) Name of Insured (in full) _____
 (b) Address in full _____
 (c) Profession or occupation _____ (d) Age last birthday _____
 2. (a) No. of Policy _____ (b) Date of Policy _____ (c) Date of last payment of premium _____
 3. (a) Date and time when accident occurred _____ on the _____ day of _____
 _____ (date) _____ (month)
 _____ 20_____ at _____ O'clock In the _____
 (b) Where it happened _____
 (c) Name and address of Witness _____
 4. How did the accident occur? _____
 5. Nature of injury received: _____
 (if to limb or eye, state whether right or left) _____
 6. (a) Nature of disablement _____
 (b) Extent of disablement _____
 Confined to house from _____ to _____ Partial disablement from _____ to _____
 (d) Present state of incapacity _____
 7. Name and Address of Surgeon or Doctor in Attendance _____
 8. (a) Where and when can a Medical Officer of the Company visit you if necessary? _____
 (b) Name of nearest Railway Station and distance there from _____
 9. (a) Are you insured in any other Office or Offices granting compensation for accident? _____
 (b) If so state name and address of Company or Companies and amount of insurance _____
10. If you are claiming for Temporary Total Disablement, does your weekly income immediately before the accident exceed by 50% the total weekly compensation you will receive now from this and all other sources? _____

I hereby declare that the foregoing statements are made by myself and are true in all respects and that I have not attempted to conceal from the Company anything with which it ought to be made acquainted, and also that I have not abstained from my usual occupation longer than is absolutely necessary; and I agree that if I have made, or, in any further declaration the Company may require, shall make any false or fraudulent statement or any suppression, concealment or untrue avertainment whatever, the Policy shall be void, and my right to compensation absolutely forfeited and I am willing, if required, to make a Statutory Declaration before a Justice of the Peace of the truth of the whole of the foregoing statement or any other statement I make in connection with this Claim.

Signature of Claimant: _____
Date: _____

Witness: _____
Address: _____

CERTIFICATE TO BE FILLED UP AND SIGNED BY AN EYE WITNESS OF THE ACCIDENT.

I hereby certify that I was present when the Accident occurred to Mr _____
 _____ on the _____ day of _____ 20_____ in the
 manner stated by him overleaf, that it *was caused by _____
 _____ was not caused
 his wilful act, and that he was not under the influence of intoxicating liquor at the time.

Signature: _____
Name: _____
Address: _____

 Occupation _____
Date: _____

Strike out which is not applicable.