

CLAIMANT'S STATEMENT FOR PERSONAL ACCIDENT CLAIM

PART A - COMPLETE IN FULL

1. FULL NAME (Please Print) 		9. Give date and hour when accident occurred Day Month Year at Hours
2. POLICY NUMBER	3. AGE	10. On what date did you stop performing your occupational duties Day Month Year
4. HEIGHT	5. WEIGHT	
6. RESIDENCE ADDRESS No Street Area City		11. Have you done any work since commencement of accident If yes, explain
7. BUSINESS ADDRESS No Street Area City EMPLOYER NATURE OF BUSINESS		12. How do you spend your time? 13. Were you confined to hospital? Yes ☐ No ☐ If yes, from to
8a. OCCUPATION 8b. Average earnings per week 8c. DESCRIBE DUTIES		14. Were you confined to house? Yes ☐ No ☐ If yes, from to 15. When did you resume work? Full time from Part time from
16. Give date consulted and name and address of Physician consulted by you on account of present condition Day Month Year Name Address		
17. What other Personal Accident Insurance providing for disability benefits do you have? Name of Company Address Amount of weekly indemnity		

PART B - DETAILS OF THE ACCIDENT

A. What bodily injuries did you sustain caused wholly by the Accident? . Any evidence of visible contusion or wound?	G. How long were you partially disabled weeks.....day H. Describe fully your present condition.
B. Where and how did the accident occur?	If question 1 to 17 and A to H above have been completed by a person other than the claimant, please state Your name Your address Your relationship to the disabled person
C. If partial disability is claimed, state the particular duties you were unable to perform during the entire period of partial disability?	
D. Were you on vacation or unemployed during any period of disability?	The reason why you have completed the questions Date Signed
E. Has disability resulting from accident ended and is this your full claim?	
F. How long were you totally disabled weeks.....days.	

NOTE: This blank is furnished to the Insured without prejudice to or waiver of any right to defense that the Company may have relative to any claim filed hereunder. The foregoing statements are full and true to the best of my knowledge and belief and agree that payment according to the terms of the policy, for the period of disability as herein indicated, shall be a full satisfaction and discharge of any and all claims, the cause of which originated prior to the date hereof.

Signed:

Date:

WITNESS.....

STATEMENT OF ATTENDING PHYSICIAN OR SURGEON

THE INSURED IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY

NAME OF PATIENT:	ID/PASSPORT No.:
HISTORY: (a) When did the accident occur?	(a)
(b) Give details of accident Any evidence of visible contusion or wound?	(b)
(c) Was patient at the time of this accident affected with any previous injury	(c) Yes ☐ No ☐ If yes, please give particulars
(d) To your knowledge, did he have any infirmity or physical impairment prior to this accident? If so, did it contribute to cause the accident or prolong the disability?	(d) Yes ☐ No ☐ If yes, please give particulars
(e) In your opinion, was the injury caused directly by violent accidental external and visible means?	(e) Yes ☐ No ☐ If yes, please give particulars
(f) For what period was patient i. Hospital confined ii. House confined iii. Bed confined iv. Ambulatory	(f) From To From To From To From To

DIAGNOSIS

If injury involved eye or limb, state whether right or left. If fracture or dislocation occurred, state which and whether compound, complete or incomplete. If fracture of long bones occurred, state whether through head or shaft.

TREATMENT	DATE OF FIRST VISIT
	DATE OF LAST VISIT
	TOTAL NUMBER OF VISITS

DESCRIBE PRESENT CONDITION: Indicate if recovered, improved, unimproved or retrogressed

DEGREE AND LENGTH OF DISABILITY	From To
(a) From what dates has the patient been unable to perform any part of his occupation?	From To
(b) From what dates has the patient been unable to perform some part, but not all, of his occupation?	From To
(c) If not working, when do you think he will be able to work?	Approx. Date Indefinite Never

I hereby certify that I am the attending physician/surgeon for Mr./Mrs./Miss and that my answers to the foregoing questions are correct and true to the best of my knowledge and belief.

DATE: SIGNED:
Attending Physician's signature
Name
Qualifications
Address
Telephone

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Regulated by the Insurance Regulatory Authority

