

**Personal Accident Claim Form**

It is important that a complete answer be given to every question. If insufficient space is provided for your answers, please continue on a separate sheet.

| CLAIM NO. | ACCOUNT NO. | POLICY NUMBER | RENEWAL DATE | NAME OF AGENCY |
|-----------|-------------|---------------|--------------|----------------|
|           |             |               | / /          |                |

**INSURED OR POLICYHOLDER**

Full Name \_\_\_\_\_

Postal Address \_\_\_\_\_

Tel No. \_\_\_\_\_

**INJURED PERSON**

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Private Address \_\_\_\_\_ Tel No. \_\_\_\_\_

\_\_\_\_\_ Pager No. \_\_\_\_\_

Business Address \_\_\_\_\_

\_\_\_\_\_ Handphone No. \_\_\_\_\_

Employment/Occupation \_\_\_\_\_

**ACCIDENT**

Date \_\_\_\_\_ Time \_\_\_\_\_ am/pm\*

Place \_\_\_\_\_

State fully what happened \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What was the Injured Person doing at the time? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\* DELETE AS REQUIRED

## INJURY OR ILLNESS

Nature of injury or illness \_\_\_\_\_

Has he previously suffered from an injury to the same part or a similar illness? YES/NO\*

If YES, give details \_\_\_\_\_

How long has he been disabled from engaging in or attending to his usual employment or occupation as a result of the injury or illness?

(a) TOTALLY : From \_\_\_\_\_ to \_\_\_\_\_

(b) PARTIALLY : From \_\_\_\_\_ to \_\_\_\_\_

Are you still totally unable to attend to any portion of your business. \_\_\_\_\_

On what dates you were able to attend:

(1) To a portion of your usual business or occupation (1) \_\_\_\_\_

(2) To the whole of your usual business or occupation (2) \_\_\_\_\_

## OTHER INSURANCE OR COMPENSATION

Is the injured person claiming under any other insurance or receiving compensation from any other source? YES/NO\*

If YES, give details \_\_\_\_\_

Have you ever made a claim for compensation in respect of accidental injury from any Insurer? If so, please give particulars.

\_\_\_\_\_

## DECLARATION

I/We declare that these particulars are true and correct to the best of my/our knowledge and belief

Injured person's signature \_\_\_\_\_ I/C No. \_\_\_\_\_ Date \_\_\_\_\_

Insured's signature / \_\_\_\_\_ I/C No. \_\_\_\_\_ Date \_\_\_\_\_  
Company Stamp

\*DELETE AS REQUIRED

### Notes:

1. It is important that the Medical Report opposite should be completed by a fully qualified and registered medical practitioner.
2. If you are claiming for reimbursement of medical or other expenses full details and documentary evidence must be provided.
3. If compensation is related to salaries or wages a signed statement should be attached, giving the total remuneration paid by the Insured or Policyholder to the injured person during the twelve months prior to the accident or illness.
4. The Claimant must obtain at his own expense the medical report from his Medical Attendant.
5. The issue of this form is not an admission of liability by the company.

## MEDICAL REPORT

|   |  |
|---|--|
| 1. Name of Patient  |  |
| 2. What injuries have the Patient sustained?<br>(a) Is injury likely to cause loss of the use of the part injured?<br><br>(b) Is such loss likely to be permanent? If so, to what extent (percentage)?        | (a)<br><br>(b)   |
| 3. The date you first attended to the Claimant in respect of the injuries sustained in consequence of the accident described on the face of this form.<br><br>Whether you are still attending to the Claimant |  |
| 4. How long has the Patient been totally or partially disabled from engaging in or attending to his usual employment or occupation as a result of these injuries or illnesses?                                | Totally from _____ to _____<br><br>Partially from _____ to _____ |
| 5. How much longer do you consider such disablement will continue?  | Totally from _____ to _____<br><br>Partially from _____ to _____ |
| 6. Has the Patient any other disease or physical defect?<br>If YES, (a) What is the nature?<br><br>(b) To what extent may recovery be effected thereby?   | YES/NO*<br><br>(a)<br><br>(b)                                    |
| <p>Name of Medical Attendant</p> <p>Signature: _____ Qualifications: _____</p> <p>Address: _____ Date: _____</p>  |  |