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STATED BENEFITS & PERSONAL ACCIDENT CLAIM FORM

This form is intended for STATED BENEFITS & PERSONAL ACCIDENT type claims.
The Insurer reserves the right to request completion of their prescribed claim form if deemed necessary.

(TO BE COMPLETED AND SIGNED BY CLAIMANT)
The issue of this form is not an acknowledgement of any liability by the Insurance Company

DETAILS OF THE INSURED ("YOU") & INSURER REFERENCE

INSURED			
POSTAL ADDRESS		TELEPHONE	OFFICE: FAX:
			HOME:
			CELL:
OCCUPATION		E-MAIL	
INSURER		POLICY NO	

PARTICULARS OF CLAIM

FULL NAME OF INJURED PERSON			
FULL ADDRESS OF INJURED PERSON			
OCCUPATION OF INJURED PERSON		AGE	
STATE AMOUNT OF SALARY OR WAGES PAID TO THE INJURED PERSON DURING THE TWELVE MONTHS PRIOR TO THE ACCIDENT			
WHEN DID THE ACCIDENT OCCUR? DATE		TIME	
WHERE DID THE ACCIDENT OCCUR?			
HOW DID THE ACCIDENT OCCUR? (FULL DESCRIPTION			
DID THE ACCIDENT OCCUR WHILE THE INURED PERSON WAS ENGAGED UPON YOUR BUSINESS?	YES	NO	
DESCRIBE INJURIES			
NAME & ADDRESS OF DOCTOR ATTTENDING TO INDURED PERSON			
DATE INJURED PERSON CEASED WORK		WHEN DO YOU EXPECT HIM / HER TO RESUME WORK?	
STATE WHETHER HE / SHE IS FULLY OR PARTIALLY INCAPITATED FROM WORK			

DECLARATION

I/WE WARRANT AND DECLARE THAT THE PARTICULARS GIVEN ABOVE ARE TRUE IN EVERY RESPECT AND THAT I/WE HAVE NOT WITHELD ANY INFORMATION WHATSOEVER IN CONNECTION WITH THE CLAIM. I/WE AGREE THAT, IF ANY OF THE ABOVE ANSWERS OR PART THEREOF, ARE UNTRUE, MY/OUR CLAIM OR COMPENSATION SHALL BE FORFEITED AND THE CONTRACT OF INSURANCE SHALL BE NULL AND VOID.

SIGNATURE: Insured / Broker / Sub-agent	**DATE**	**TIME**

THIS FORM SHOULD BE COMPLETED FULLY WITHOUT DELAY AND FORWARDED TO THE COMPANY AT ON OF THE ABOVE ADDRESSESTOGETHER WITH A CERTIFICATE FROM THE INJURED PERSON'S DOCTOR. THE ISSUE OF THIS FORM DOES NOT IMPLY AN ADMISSION OF LIABILITY

DOCTOR'S CERFICATE

NAME OF PATIENT	
WHEN DID HE / SHE FIRST CONSULT YOU ABOUT THIS ACCIDENT?	
ARE YOU STILL IN ATTENDANCE?	YES / NO
ARE YOU HIS / HER USUAL DOCTOR?	YES / NO
STATE NATURE OF INJURY AND HOW SUSTAINED	
IS HIS / HER CONDITION DUE SOLELY TO THE ACCIDENT?	YES / NO
STATE WHETHER HIS / HER CONDITION IS COMPLICATED BY ILLNESS OR DISEASE AND WHETHER HE / SHE HAS ANY PHYSICAL INFIRMITY.	
IS HE / SHE TOTALLY INCAPACITATED FROM ATTENDING TO ANY PART OF HIS / HER OCCUPATION?	YES / NO
DATE OF COMMENCEMENT	
PROBABLE DURATION FROM DATE OF THIS CERTIFICATE	
IF TOTAL INCAPARICY HAS CEASED, DATE OF CESSATION	
IS HE / SHE ONLY PARTIALLY INCAPACITATED IN THE SENSE THAT HE / SHE IS UNABLE TO ATTEND TO A SUBSTANTIAL AND ESSENTIAL PART OF HIS / HER OCCUPATION?	YES / NO
DATE OF COMMENCEMENT	
PROBALE DURATION FROM DATE OF THIS CERTIFICATE	
IF PARTIAL INCAPACITY HAS CEASED, DATE OF CESSATION	
IS HE / SHE ON YOUR ADVICE TO THE HOUSE OR HOSPITAL?	YES / NO
GENERAL REMARKS	

SIGNATURE:	**DATE**
QUALIFICATION(S)	
ADDRESS	