PERSONAL ACCIDENT CLAIM FORM

CLAIM NO: .... POLICY NO: ....

THE COMPANY DOES NOT ADMIT LIABILITY BY THE ISSUE OF THIS FORM

INSURED'S NAME: ....

ADDRESS: ....

BUSINESS OR OCCUPATION: .... TELEPHONE NO: ....

DESIGNATION:.. AGE:...

DATE OF LOSS: ....TIME: ....PLACE: ....

1. How did the accident happen and what was the injured/deceased doing at the time?

....

....

....

2. Please give the names and addresses of any witnesses of the accident?

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....

....

3. What injuries did the employee sustain? (or cause of death)

....

....

....

4. (a) What is the name and address of the doctor attending to the

injured/deceased?

....

(b) Is he your usual doctor? ....

5. How long has he/she been temporarily totally disabled?

From: .... To: ....

6. Has he/she required medical or surgical treatment during the past five years? If, so, Please give particulars?

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7. (a) Are you claiming under any other policy for this accident?

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(b) If so, please give details

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DECLARATION

We declare that the above answers are true and complete.

DATE:.. INSURED'S SIGNATURE:..............................