

## PERSONAL ACCIDENT CLAIM FORM

### 1. Insured Details

Name of Insured: .....

Address: .....

Email address: .....

TIN No: .....

Policy No.: .....

Period of Insurance: .....

Trade of Business: .....

Telephone No.: .....

### 2. Details Of Accident

Date: ..... Time: ..... (am or pm)

Place: .....

Brief details of accident: .....

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3. a) Details of Personal Injuries:

Name	Age	Occupation	Monthly Salary	Nature of Injuries

b) Name and address of hospital/ clinic attended:

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 .....

c) Is there any other insurance cover in force?

Yes ( )                  No ( )

d) (i) Has any claim been made upon you?

Yes ( )                  No ( )

(ii) If so, by whom and for what amount?

.....  
 .....

**(Note: Any correspondence must be forwarded immediately to the Company.)**

e) Has the employee(s) resumed work?

Yes ( )                      No ( )

If so, when?

.....  
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f) Have you in any way admitted liability?

.....

g) Give names and addresses of witnesses:

- 1. ....
- 2. ....
- 3. ....

(Note: Please attach statement from witnesses)

4. Declaration

I / We declare the foregoing particulars to be true to the best of my/ our knowledge and belief, and I/ We further declare that I/ We do not hold any other policy indemnifying me/us in respect of this accident.

Date: ..... Signature of insured: .....