PERSONAL ACCIDENT CLAIM FORM

The issue of this form is not to be taken as an admission of Liability

Claim No._____ Policy No_____

1. PERSONAL DETAILS

Name a) Insured_____

b)Claimant_____

Address _____

Occupation_____Age_____

2.**DETAILS OF ACCIDENT**

Time and Date_____

Place and Location_____

Details of Duties_____

_____

Description of Accident_____

_____

3. DETAILS OF INJURIES

a) Description of the injury

b) Period of disablement, in case of temporary disablement

c) Nature of disablement, in case of permanent disablement

d)Death ,cause of death as certified and Name of the Medical Examiner

4. Where injured person is to be examined and Name of the Examiner.

Date :

Place : Signature of the Insured-