



Personal Accident Insurance Claim Form (Particulars of Accident)

Policy No.....

Claim No.....

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

TO BE COMPLETED BY THE INSURED

1	(a) Name of Insured (in full):			
	(b) Address in Full			
	(c) Profession or occupation of the Injured:	(d) Age of last birthday:		
2	Policy No.	Sum Insured	Table of Cover	Period
3	(a) Date of Accident:			
	(b) Time of Accident:			
	(c) Where it happened:			
	(d) Name and address of the witness			
4	How did the accident occur?			
5	Nature of injury received (if to limb or eye state whether right or left)			
6	(a) Nature of disabiement			
	(b) Extent of disablement			
	Confined to House	From	To:	
	Partial Disablement			
	(c) Present State of Incapacity			
7	(a) Are you insured in any other office or offices granting compensation for accident?			
	(b) If so, state name and address of company or companies and amount of Insurance			

I/We hereby declare that the foregoing statement are made by myself/ourselves are true in all respect and that I/We have not attempted to conceal from the Company anything with which it ought to be made acquainted, and also that I/We have not abstained from any usual occupation longer than absolutely necessary and I/We agree that if I/We have made, or in any further declaration the Company may require, shall make any false or fraudulent statement or any suppression, concealment or untrue averment whatever, the Policy shall be void, and my/our right to compensation forfeited.

Signature of the Insured: _____

Date _____

COMPANY SEAL