PICIC INSURANCE

PICIC Insurance Limited
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*Policy No.*____________________

PERSONAL ACCIDENT CLAIM FORM

To be completed by the insured and his doctor and returned within sevenb days of receipt bt the insured.

1. Name of Insured in full.	
2. (a) Age next birthday (b) Present profession or occupation:	
3. Present address of insured	
4. If claim is in respect of bodily injury resulting from accident (a) When and where did the accident occur ?	Date________ Date________ Date________
(b) How did it happen ? (Full description to be given)	
(c) Name and addresses of any witnesses of the accident:	
(d) Name and addresses of Doctor who attended insured immediately after the accident :	
(e) Name and address of Doctor now attending insured :	
5. Is insured entitled to compensation from any other company or any club in respect of the injury or disease for which he is claiming ? If so, full particulars to be given :	
6. Where can a medical or other officer of the company visit insured if necessary ?	
7. Nearest railway station and distance therefrom :	

Medical Report. Any claim must be supported by a report on the reverse side of the form the insured's Medical Attendant, any fee for the report being payable by the insured.

DECLARATION.

I, the undersigned, hereby declare that I am the person referred to in the above statements, which are true in every respect and made without reservation, and I hereby claim to be paid.

(a) compensation at the rate of ____________________ per week, as from the ____________________ or

(b) the total sum of ____________________ which I agree to accept in settlement of my claim.

Date________________ Signature________________

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MEDICAL REPORT

(Any fee for report is payable by the claimant.)

Name of claimant:	
ACCIDENT 1. Describe fully the cause and circumstances of the accident as stated by you:	
2. Are the appearance of the injuries consistant therewith and do you believe they were caused as stated ?	
3. Nature of Injury- please give detailed particulare :	
4. On what date did the climant first consult you in connection with this accident or disease ?	
5. Are you the claimant's usual Medical Attendant? If so how long have you know him ?	
6. Is the Claimant suffering from any injury or disease irrespective of that stated above? If ss. Please state nature of the same and to what exent recovery may be affected thereby :	
7. Is the claimant on your advice (a) confined to bed ? (b) confined to house? If so, state probable duration of such confinement form this date (C) able to get out of doors ?	(a) ________ from________ to ________ (b) ________ from________ to ________ (c) ________ from________ to ________
8. If the claimant is in your opinion unable to give any attention to his profession or occupation. Please State. (a) Date of ocommencement of total disablement : (b) Probable duration from this date :	 (a) (b)
9. If the claimant is in your opinion able to give partial attention to his profesion or occupation, Please state. (a) Date of commencement of partial disablement : (b) Probable duration from this date:	
10. If disabililty has terminated. Please state date of termination :	
11. General remarks:	

I certify that to the best of my belief the foregoing statements are correct.

signature____________ Qualifications____________

Address________ Date________