



GROUP PERSONAL ACCIDENT FORM

SECTION I: INSURED'S DETAILS

Name in full:

Full address:

Present occupation:

Date of accident:

dd/mm/yyyy

Time:

Place:

Full description of the accident:

SECTION II: MEDICAL CERTIFICATE

Regions injured. If limb, state right or left	Fracture	Dislocation	Cuts or Tears	Contusion or Crushing	Sprains	Nature and Extent of injuries

1. When was the claimant first seen by you after the accident?

dd/mm/yyyy

2. Are you still in attendance? Yes No

Between what dates (inclusive) has the claimant been confined to the hospital or house by your direction, by the injuries stated in the above report.	Hospital	House
	From: dd/mm/yyyy To: dd/mm/yyyy	From: dd/mm/yyyy To: dd/mm/yyyy

To what extent has the Claimant been necessarily disabled from business own to injuries	Hospital	House
	Totally disabled: days	If still disabled how likely to continue? Totally

Is the claimant now able to attend to business in any way? Yes No

On what day was he / she able to do so after the accident?

dd/mm/yyyy

Was the claimant at the time of the accident subject to any illness or disease irrespective? Yes No

If yes, what was the nature thereof and to what extent may the recovery of claimant be affected thereby?

DECLARATION

I/We warrant the truth of answers to the above questions and I/we declare that no information has been withheld and that the amount claimed represents my/our loss arising from the above stated occurrence.

Name:

Signature:

SIGN HERE

Date:

dd/mm/yyyy

