INSURER: ----------

Accident Insurance Claim Form
Group / Personal

Claim No:……. Policy No.:……

The Company does not admit Liability by the issue of this Form

Insured's Name:……..……

Address:……..……

Business Or Occupation:…….……Telephone No.:…….……

Injured Employee's Name:…..……

Designation:…….Age:…….……

Monthly Salary Prior To Accident:……..……..……

Date of Accident:……..……...Time:……..…..……Place:…….

1. How did the accident happen and what was the employee doing at the time?

……

……

2. Please give the names and addresses of any witnesses of the accident?

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3. What injuries did the employee sustain?

……

…… (a) What is the name and address of the doctor attending to the employee?…….

Is he your usual doctor?……..……

4. How long has he/she been temporarily totally disabled?

From:…….To:……..……

5. Has he/she required medical or surgical treatment during the past five years? If, so, Please give particulars?

……

…… (a) Are you claiming under any other policy for this accident?

……

(b) If so, please give details

……

……Documents to be presented in support of claim

- Police Report where applicable
- Medical Report
- Medical Bills
- Pay slip in support of Salary

Declaration

We declare that the above answers are true and complete.

Date:……..……Insured's Signature:……