Personal Accident Claim Form

10 Sabre Close, Green Farm Business Park, Quedgeley, Gloucester GL2 4NZ
Telephone: 01452 361602 or 361649 Facsimile: 01452 361604

- **When completing this form, please tick the appropriate boxes and answer all questions using BLOCK CAPITALS.**

1 You the Policyholder

Name of the Insured			
Address			
Town		County	
Postcode		Date Premium Paid	
Telephone Number		Policy Number	

Value Added Tax. Are you a registered person or company? Yes ☐ No ☐

Age | Height | Weight

2 Circumstances of the Claim

a Occupation (please state all if more than one)

Brief description of job content i.e. usual duties and responsibilities

b Are you self employed? Yes ☐ No ☐

If **yes**, give particulars of clerical or supervisory duties

c Name and address of employers

d Nature of present incapacity

e Brief history of all previous illness/accidents including any earlier incapacity as a result of present condition. Please give approximate dates

f When were you first medically treated for present condition?

g Name and address of doctor in attendance

If not your usual doctor also give his/her name and address

2 Circumstances of the Claim *continued*

h State if totally or partially disable and give details.
Note: Total disablement arises when a claimant is continuously unable to attend to any part of usual occupation

i Totally

from | to

ii Partially

from | to

i Has incapacity confined you to

i Bed

from | to

ii House

from | to

j Give date of return or expected return to work

(dd/mm/yyyy)

k Are you claiming under any other policy? Yes ☐ No ☐

If **yes**, state name of insurance company and policy no.

3 Accident Report

a Date (dd/mm/yyyy) | Time am/pm

b Place

c State activity/occupation actually engaged in at time of the accident

d If taking part in organised sport state:

i amateur or professional capacity

ii name of Club/Team you were representing

e Please describe accident

I declare that the answers given are to the best of my knowledge and belief true and comply in all aspects. I have no objection to the Company approaching the doctor for a full report on my present condition or previous medical history.

Signature | Date (dd/mm/yyyy)

Please ask for the doctors co-operation in completing the medical report below which must be returned as soon as possible after accident, whether or not fully recovered

4 Medical Report (to be completed by Doctor)

a Where and when did you first attend Patient in consequences of present incapacity?

b Describe nature of present condition/injuries

c If incapacity is the result of an accident are the injuries solely and directly attributable to and consistant with accident described by the patient?

d Have you previously treated the patients for the present conditions?

Yes ☐ No ☐

If **yes**, please give brief details

4 Medical Report (to be completed by Doctor) *continued*

e Are you aware of anything in patient's previous history which may contribute or prolong present incapacity? If so please advise details

f Please state period during which unable to attend to any part of usual duties or occupation (dd/mm/yyyy)

From to

g Probable further duration

h Please state period during which able to attend to some part if not all usual duties or occupation (dd/mm/yyyy)

From to

i Probable further duration

j Date of return or expected return to work

(dd/mm/yyyy)

k Remarks

Signature

Date (dd/mm/yyyy)

Address

NIG100743A/05/13