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Claim Form Personal Accident Insurance

FOR OFFICE USE ONLY

Claim No.:

IMPORTANT NOTE

You are to disclose to us, fully and faithfully all the facts which you know or ought to know, otherwise the claim submitted hereunder may be declined.

A. POLICY DETAILS

Policy No.	
Policyholder/Insured's Full Name	
Email	Mobile No.
Correspondence Address	
Postcode	

B. CLAIMANT'S DETAILS

Full Name	Relationship with the Insured
Email	Mobile No.
Correspondence Address	

C. ACCIDENT & INJURY DETAILS

DATE (dd/mm/yy)	Time	Location
Type of Loss/Damage	<input type="checkbox"/> Death <input type="checkbox"/> Permanent Loss / Disablement <input type="checkbox"/> Temporary Total Disablement <input type="checkbox"/> Temporary Partial Disablement <input type="checkbox"/> Medical Expenses	
Description of Injury Sustained (e.g. body part injured, injury type)		Have you injured the same part before? <input type="checkbox"/> YES <input type="checkbox"/> NO
Date on which you resumed duty?		
Have you made a claim against any other party in respect of this event? If yes, please provide details	Name of other party / insurance company :	
	Description of claim :	

E. DECLARATION

I/We declare that the particulars given on this form are true and complete, copies of documents are identical with the original one, and that I/We have not withheld from the Company, any information within my/our knowledge connected with the accident.

Signature of Insured:

Date:

(If a Limited Company, give status of signatory and affix company's rubber stamp)

DOCUMENTS REQUIRED FOR CLAIM SETTLEMENT

Below is a list of minimum documentation required to process your claim. In certain circumstances, additional information may be required in order for further confirmation.

Type of Loss/ Damage	Documents Required (Please tick against the documents you have submitted.)
Basic for all types	<input type="checkbox"/> Medical Certificates <input type="checkbox"/> Original Hospital/ Medical Memos, Bills & Receipts <input type="checkbox"/> Medical Reports <input type="checkbox"/> Police Report/ Accident Report – for motor accident injury claim or criminal incident <input type="checkbox"/> Employment Letter & 3-month salary slips - for Group PA on un-named basis only
If applicable below:	
Fatal Accident	<input type="checkbox"/> Certified True Copy (CTC) of Death Certificate/ Post-Mortem Report/ Burial Certificate <input type="checkbox"/> CTC of Deceased's ID Card /Employment Letter & 3-month salary slips - for Group PA only <input type="checkbox"/> CTC of Letter of Administration / Distribution Order - for only if no named beneficiary for individual policy

MEDICAL REPORT

Private & Confidential

This form is to be completed by the Patient's Attending Doctor. The cost of this medical report is to be borne by the Claimant.

1	Full Name of Patient (Claimant)					Date of Accident (dd/mm/yy):
2	Cause of Injury					
3	Nature and Extent of the Injury. Describe complications, if any	Final Diagnosis	Part of Body (State Left/Right limb)		Symptoms	
4	Date You First Consulted For This Injury/Condition	DD / MM / YY		Date of Hospitalisation (if applicable)	Admitted DD / MM / YY	Discharged DD / MM / YY
	Treatments	Completed	Ongoing	Other treatments, if any	Completed	Ongoing
	<input type="checkbox"/> X-ray	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Surgery	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Special Diagnostics	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
5	How long has the Patient been disabled from engaging in or attending to usual employment or occupation as a result of these injuries?	Totally	From (dd/mm/yy):		To (dd/mm/yy):	
		Partially	From (dd/mm/yy):		To (dd/mm/yy):	
6	Any Sign of Pre-Existing Injury? If yes, please provide details (Nature & Cause of Injury/ Symptom)					Date Treated (estimated)
6	Do you think current accident aggravated injury? If yes, please provide reasons for your opinion					
7	At the time of accident, was the patient suffering from any illness? If yes, please provide details					
8	Details of any circumstances which may have contributed to the accident and/or lengthen the period of disability. (e.g. physical impairments, medical history or intoxication)					

9	Any other information or professional advice that should be made known to the insurer?	
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DECLARATION

I/We declare that the particulars given on this form are true and complete and that I/We have not withheld from the Company, any information within my/our knowledge connected with the accident.

Signature of Doctor/Specialist: _____

Name of Doctor/Specialist: _____

Date: _____

Official Stamp of Hospital/Clinic 