

If you are incapable of work through sickness or accident please complete this form clearly and return with the Medical Certificate(s) obtained from your Doctor. Please use a separate sheet of paper if there is insufficient space on this form.



## Group Personal Accident Claim Form

### Details of Policyholder

Name:	Policy Number:
Occupation:	

Address:	Telephone Home:
	Telephone Work:
Email	Mobile:

### Insured Person

Name:	Date of Birth:
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Address:	Telephone Home:
	Telephone Work:
Email:	Mobile:

Your occupation / business
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Date first absent from work:	Are you totally disabled from working?
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When does your Doctor say you will be fit to resume work?
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Name & address of the Doctor who signed the attached Medical Certificate:
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Name & address of your usual Doctor, if different from above.
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### Accident Claim

Date & time of accident:	Place:
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How did the accident occur?
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What are your injuries?
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Have you had a similar accident before? If so, please give details.
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I declare the above statement and particulars are true and complete. I claim benefit from / /

**Date:** / /

**Signature:**