FIRST ASSURANCE COMPANY LTD

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PERSONAL ACCIDENT CLAIM FORM

(If unable to reply personally, this form may be filled in on behalf of the Claimant).

Claimant's name (in full) _____
Address _____
Postal Code _____ Town/City _____
Present Occupation _____ Present Age _____
Policy No. _____ Date of payment of last premium _____

1. (a) Date of Accident? (b) Where did it occur? (c) Describe fully how it happened (d) Give name, occupation and address of a Witness of the Accident	(a) _____ Time: _____ O'clock _____ m (b)_____ (c) _____ _____ _____ (d) Name: _____ Occupation: _____ Address: _____ Postal Code: _____ Town/Witness: _____
2.(a) Describe the nature and extent of the injuries you have received (b) Give names and addresses of the Doctors who have attended you for these injuries	2.(a) _____ _____ (b) Names: _____ Address: _____ Postal Code: _____ Town/City: _____
3. (a) State the number of days you have been ENTIRELY confined to your Bed, Room or House (b) If you are still confined to your Bed or Room or House, state which	3.(a) To Bed for _____ days from _____ to _____ To Room for _____ days from _____ to _____ To House for _____ days from _____ to _____ (b) _____
4. (a) State the extent and duration of your inability to attend to your business or occupation (b) If you still disabled, state how much longer the disability is likely to continue	4.(a) I have been disabled: PARTIALLY for _____ days from _____ to _____ WHOLLY for _____ days from _____ to _____ I am now _____ disabled, (insert "wholly", "partially" or "not at all". (b) _____
5. Have you since the accident personally directed or supervised or given any attention whatever to any part of your business or occupation? If so, give full particulars and dates	5.
6. (a) Are you entitled to receive compensation from any other Company or other source? If so, give full particulars (b) Have you ever claimed compensation from Any Company? If so, give full particulars	6. (a) _____ (b) _____

7. Are you perfectly free from any physical Defect, Infirmity, or Disease?	7.
8. Are you at the present time able to state the Amount for which you are willing to settle the Claim? **(The compensation is based upon the actual period of disablement).**	8.

DECLARATION

I, the undersigned, hereby declare that I am the person referred to in the above statement, which is true in every respect, and made without reservation.

I hereby authorize the company to apply to my Medical Attendant mentioned above, for a Report to be furnished at my expense in the form used by the Company for the purpose.

Date _____ Signed _____

NOTE: -The certificate overleaf must be completed by tour Doctor before this Claim Form is forwarded to the Company.

MEDICAL CERTIFICATE

In order to establish his claim, the claimant must obtain and forward to the company a certificate from a duly qualified and registered Medical Practitioner, and it is essential that this form be filled up as minutely as possible so that the Medical Officer of the Company may properly understand the nature of the case.

The Medical Attendant of the Claimant is requested to state:

1.The Name and Occupation of the claimant}		
2. The exact nature and extent of the injuries caused by the accident. -If a Hand or an Arm, a Foot or a Leg, state whether is the RIGHT or LEFT.		
Regions	Nature and extent of injuries	
3. Whether the claimant has suffered or is now suffering from any constitutional or local disease or physical infirmity. If so, state the nature of such disease or infirmity and to what extent it effects the disablement		
4. (a) When and where you first attended the claimant }At _____ At _____ O'clock _____ month _____ day of _____ {If still Attending_____} (b)Are you still attending him?		

5. To what extent the above accidental injuries have **necessarily** disabled the claimant from giving attention to business	Claimant has been disabled Totally from _____to _____ Partially from _____ to _____
Total Disablement arises when the claimant is rendered completely incapable of attending to any part of his ordinary profession, business or occupation. **Partial Disablement arises when the Claimant is so little injured, or has so far recovered from injuries as to be capable of attending to some portion of his ordinary profession, business or occupation.**	
6. (a) The further disability (if any) will in my opinion continue (i) For days/months …….. entirely (ii)For days/months ……. partially From the present time.	
(b) if so, what is the percentage	
7. If the injury sustained by the claimant is not specified in the Permanent Disability Scale, what percentage do you consider would be consistent with the percentages laid down in the scale having regard to permanent loss or reduction in the earning capacity of the claimant in any business or occupation.	
8.(a) If the Claimant is now, in any way, attending to Business, on what day he first commenced doing so after the accident? (b) If not, whether you consider Claimant fit personally to supervise or direct his Business or Occupation?	(a) (b)
9. Have you any reason to think that the patient was not perfectly sober at the time of the accident?	
10. Is there any information, professional or otherwise that you consider should be known to the company?	

REMARKS (if any)

I certify that I have satisfied myself by personal examination that the claimant has sustained an accident causing injuries as above described.

Signature _____ Qualifications _____

Date _____ Address _____