ACCIDENT CLAIM FORM

STATEMENT BY Employee

A. DETAILS

Scheme name:_____

EMPLOYEE DETAILS

Name:_____

Identity Number: _____Date of Birth:

ACCIDENT DETAILS

Date of Incident/Accident:

Description of the incident/accident. _____

_____

Date of first consultation with a doctor:

Name of Attending Doctor:

_____

Kindly provide details of doctors and the hospitals consulted in connection with this incident.

DOCTOR'S NAME AND HOSPITAL	SPECIALITY	CONTACT DETAILS	DATE

Please give full details of current treatment.

_____

_____

Date of last treatment:

How successful has the treatment been?

_____

_____

DOCTOR'S DECLARATION

I certify that the above information is, to the best of my knowledge and belief, true and accurate, and that no information has been withheld, nor has any information regarding the circumstances been omitted.

Doctor's Full Name: _____

Registration Number: _____ **Telephone:** _____

Signature_____ Date: _____

Click to Submit

Company's Stamp