ACCIDENT CLAIM FORM

Statement by Doctor

SCHEME DETAILS

Scheme name: ____

EMPLOYEE DETAILS

Name: ____

Identity Number: ______________________________ Date of Birth: D D M M Y Y Y Y

ACCIDENT DETAILS

Date of Incident/Accident: D D M M Y Y Y Y

Description of the incident/accident.

____

____

____

When were you first consulted for the incident? D D M M Y Y Y Y

Can the injuries/disability be ascribed to having been caused directly through the abovementioned accident?

____

Did this injury result in total and permanent loss of:

1. A limb or organ through severance? ______________________________
2. The use of a limb or organ? ______________________________
3. The ability to follow any occupation? ______________________________

If any of the answers to questions is in the affirmative, please motivate: ____________%

To your knowledge, can the present disability or loss of limb or organ in any way be traced to any previous injury or illness?

____

If so, please describe fully:

____

____

____

What is the current status of the patient's condition?

____

____

____

(PLEASE ATTACH COPIES OF RESULTS FOR ALL SPECIAL INVESTIGATIONS PERFORMED)

Cannon Life Assurance (K) Limited

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LIFE ASSURANCE

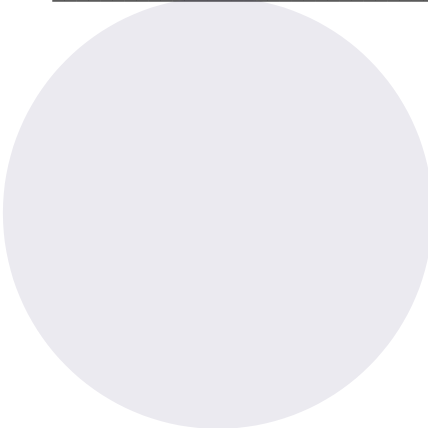
DOCTOR'S DECLARATION

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: | D | D | M | M | Y | Y | Y | Y |



Doctor's Stamp

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