Cannon
GENERAL INSURANCE

GROUP PERSONAL ACCIDENT CLAIM FORM

Issuance of this form is not taken as admission of liability

SECTION 1. CLAIMANT'S DETAILS (To be completed in full)

Policy Number………………………………..........

1. Insured's/Employer's Name…………………………………………………………………………

a. Address: …………………………………………………..…………………………………………

…………..……………………….…………………………………………………………………

b. Claimant's Name: ……………………………………………………………………………

c. Age: …………………………………… Height:……………………… Weight:…………………………

d. Occupation:…………………………………….. Average Earnings:…………………………………...

e. Describe Duties:……………………………………………………………………………………...................

....

2. Particulars of Accident: Date:………………… Time: ………………… Place:………………….......

Describe the accident/Injury:……………………………………………………………………………

……..

a. Action after Accident: Where you moved to hospital?. .... (Yes/No).

b. Name of Hospital:…………………………………………………………

c. Were you Admitted?................(Yes/No)..If Yes From Date……………..to………………..…

d. Were you given a sick off:.....(Yes/No). If Yes. From Date………….to………………………

e. When did you resume work?..Full Time……………………..Part Time…………………………

f. Do you have any other Group Personal Accident Policy? .... (Yes/ No)

g. Are you entitled to recover medical/hospitalization expenses under any other medical/hospitalization scheme?. ....(Yes/No)

If Yes. Give Name of scheme…………………………………………………………………........

Signed:…………………………………………………… Date:………………………………………

SECTION 2: TO BE FILLED IN BY HOSPITAL AUTHORITIES/PHYSICIAN OR SURGEON

THE INSURED IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY

Name of Patient: .... ID NO: ....

1. Date of admission: .... Date of discharge: ....

a. **Diagnosis:** Nature of Injury:...

b. In your opinion, was injury caused directly by violent accidental external and visible means?

Give particulars:...

c. Was patient at the time of the loss affected with any previous injury.................... (Yes/No)

d. Particulars of Treatment: ....

e. Describe the Present condition: (Recovered, improved, unimproved, retrogressed)

....

2. DEGREE AND LENGTH OF DISSABILITY

a. Permanent Disability. (Patient unable to perform all or part of his/her duties due to injury for life)

i. Indicate the percentage of Residual Permanent disability ....

Give Details..

ii. Indicate the period he/she may be unable to perform his/her duties..............................

Declaration: I hereby certify that I am the attending Physician/Surgeon for

Mr/Mrs/Miss ....

and that my answers to the foregoing questions are correct and true to the best of my knowledge and belief.

Date.. Signed..

Attending Physician's Signature

Name:.. Stamp

Qualifications:..

Address:...

Telephone:..