Cannon
GENERAL INSURANCE

CLAIMANT'S STATEMENT FOR PERSONAL ACCIDENT CLAIM

PART A - COMPLETE IN FULL

1. FULL NAME (Please Print)

2. POLICY NUMBER

3. AGE

4. HEIGHT

5. WEIGHT

6. RESIDENCE ADDRESS
No ..... Street .....
Area ..... City .....

7. BUSINESS ADDRESS
No..... Street.....
Area ..... City .....
EMPLOYER .....
NATURE OF BUSINESS .....

8a. OCCUPATION .....

8b. Average earnings per week .....

8c. DESCRIBE DUTIES .....

9. Give date and hour when accident occurred
Day ..... Month ..... Year ..... at Hours .....

10. On what date did you stop performing your occupational duties
Day ..... Month ..... Year .....

11. Have you done any work since commencement of accident
If yes, explain .....
.....

12. How do you spend your time?

13. Were you confined to hospital? Yes ☐ No ☐
If yes, from ..... to .....

14. Were you confined to house? Yes ☐ No ☐
If yes, from ..... to .....

15. When did you resume work?
Full time from .....
Part time from .....

16. Give date consulted and name and address of Physician consulted by you on account of present condition
Day ..... Month ..... Year ..... Name ..... Address .....

17. What other Personal Accident Insurance providing for disability benefits do you have?
Name of Company ..... Address ..... Amount of weekly indemnity .....

PART B - DETAILS OF THE ACCIDENT

A. What bodily injuries did you sustain caused wholly by the Accident? .

Any evidence of visible contusion or wound?

B. Where and how did the accident occur?

C. If partial disability is claimed, state the particular duties you were unable to perform during the entire period of partial disability?

D. Were you on vacation or unemployed during any period of disability?

E. Has disability resulting from accident ended and is this your full claim?

F. How long were you totally disabled ..... weeks ..... days.

G. How long were you partially disabled ..... weeks .....day

H. Describe fully your present condition.

If question1 to 17 and A to H above have been completed by a person other than the claimant, please state
Your name .....
Your address .....
Your relationship to the disabled person .....

The reason why you have completed the questions
.....
Date ..... Signed .....

NOTE: This blank is furnished to the Insured without prejudice to or waiver of any right to defense that the Company may have relative to any claim filed hereunder. The foregoing statements are full and true to the best of my knowledge and belief and agree that payment according to the terms of the policy, for the period of disability as herein indicated, shall be a full satisfaction and discharge of any and all claims, the cause of which originated prior to the date hereof.

Signed: ..... Date: ....

WITNESS

STATEMENT OF ATTENDING PHYSICIAN OR SURGEON

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

NAME OF PATIENT:	**ID/PASSPORT No.:**
HISTORY: **(a)** When did the accident occur?	**(a)**
(b) Give details of accident Any evidence of visible contusion or wound?	**(b)**
(c) Was patient at the time of this accident affected with any previous injury	**(c)** Yes☐ No☐ If yes, please give particulars
(d) To your knowledge, did he have any infirmity or physical impairment prior to this accident? If so, did it contribute to cause the accident or prolong the disability?	**(d)** Yes☐ No☐ If yes, please give particulars
(e) In your opinion, was the injury caused directly by violent accidental external and visible means?	**(e)** Yes☐ No☐ If yes, please give particulars
(f) For what period was patient i. Hospital confined ii. House confined iii. Bed confined iv. Ambulatory	**(f)** From ..... To ..... From ..... To ..... From ..... To ..... From ..... To .....

DIAGNOSIS

If injury involved eye or limb, state whether right or left. If fracture or dislocation occurred, state which and whether compound, complete or incomplete. If fracture of long bones occurred, state whether through heard or shaft.

TREATMENT

DATE OF FIRST VISIT

DATE OF LAST VISIT

TOTAL NUMBER OF VISITS

DESCRIBE PRESENT CONDITION: Indicate if recovered, improved, unimproved or retrogressed

DEGREE AND LENGTH OF DISABILITY **(a)** From what dates has the patient been unable to perform any part of his occupation?	From _____ To _____
(b) From what dates has the patient been unable to perform some part, but not all, of his occupation?	From _____ To _____
(c) If not working, when do you think he will be able to work? Approx. Date Indefinite Never	_____ _____ _____

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 Physican's signature

Name _____

Qualifications _____

Address _____

Telephone _____