Britam
With you every step of the way

Personal Accident Injury Claim

This form is issued without admission of liability. No claim can be admitted unless the MEDICAL CERTIFICATE OVERLEAF be furnished at the expense of the Claimant.

The Claimant						
Name of the insured						
Address						
Occupation						
Policy Number		Telephone Nos.				
E-mail Address						
Agency						
Present Age		Height (metres & cm)		Weight (Kgs)		

1.	When did the accident occur? (State time and Date)	
2.	Give full particulars of where the accident occurred, cause and injuries sustained.	
3.	Give names and addresses of any witnesses of the accident.	
4.	Give the name and address of the medical doctor who attended you.	
5.	Give the name and address of your ordinary medical doctor.	
6.	State where and when a medical doctor or representative of the company can visit you if necessary.	
7.	State the period during which you have been totally disabled and prevented from attending to your business as the sole and direct result of the accident.	
8.	Are you still totally disabled? If not, from what date were you able to attend to or some part of your business?	
9.	Have you previously claimed or received compensation under an Accident and/or Sickness Policy? If so, please give particulars.	
10.	Are you insured elsewhere? If so, give the name of each company or Insurer, and the amount you are entitled to claim.	

I hereby declare that, I have suffered the injuries above, and warrant that the statements given are true and correct to the best of my knowledge and belief.

Date:…… Signature of Insured……..……..……

Private and Confidential

MEDICAL CERTIFICATE TO BE COMPLETED BY THE INSURED'S DOCTOR

I CERTIFY THAT *(Patient's Name)*	
Has consulted me for	
The patient was injured on	

If the patient's condition is complicated by any other disease or infirmity, please give details:

Is the present complaint likely to recur?	
The patient is totally/partially disable and will be so until	

Any comments or information deemed necessary:

Name…..…….

Qualifications……..……..

Signature…...……..

Date……..

Notes:

1. Total Disablement refers to the situation where the Insured is wholly prevented from attending to his business or occupation.

2. Partial Disablement refers to the situation where the Insured is prevented from attending to a substantial portion thereof.