



Personal Accident Claim Form



Insured

- 1. Name and full address
-
-
- 2. State (a) Number of Policy (b) Date of last payment of premium
- 3. Nature of Trade or Business

Injured Person

- 4. Name
- Full address
-
-
- 5. (a) Occupation?
- (b) Age? (c) Sex? (d) Married or Single?

Employer

- 6. Was he in your direct employ or in that of a Subcontractor?
- 7. If in your employ, how long has he been so?
- 8. Total earnings for 12 months immediately preceding the accident
- 9. State Fully the nature of the work he was doing at the time of the accident
-
-
-

Particulars of Accident

- 10. How did it occur?
-
-
-
- 11. When did it occur? at m. on the day of 20.....
- 12. State generally the nature of the injuries received
-
-
-
- 13. State to what extent the injured person is disabled, and whether absolutely prevented from following his employment
-
-
-
- 14. State what you consider will be the probable duration of total disablement.





15. Give name and address of the injured workman's Medical Attendant

.....

.....

If in hospital or nursing home, give name and address

.....

.....

16. At what hour and on what date was the injury first attended to by a Medical Practitioner?

17. Have you received notification of a Magisterial or other

Enquiry?

If so, state when and where same will be held

18. Give names and addresses of witnesses of the accident

.....

19. Was the accident caused by:

(a) Violation of rules?

(b) Carelessness of injured workman?

(c) Carelessness of any other person?

If so, who?

(d) Any defect in the condition of the premises, works, plant or machinery? If so, had such defect been brought to your notice ?

.....

.....

20. Was the injured person perfectly sober at the time of the accident?

Under whose direction was he at the accident?

Was it caused by carrying out such direction?

21. Was the injured person suffering at the time of the accident from ill-health or bodily defect or infirmity of any description?

.....

.....

22. Has the injured person previously received compensation for an accident sustained either whilst in your service or in that of a previous employer?
If so, please state:

(a) The date of the accident

(b) The amount of the compensation received

Date

Signature of Insured





23. (FOR USE BY THE MEDICAL PRACTITIONER ATTENDING OR EXAMINING THE INJURED WORKMAN)

Date admitted to hospital Discharged

In-patient No.

Attendance as out-patient from to

Nature of injury

.....

.....

(x)Permanent incapacity if applicable (report noting the specific impairments, range of motion deficits)

(x) Temporary incapacity - Likely duration of absence from work (from date of accident)

.....Days/months.

Is a further examination required before final assessment of permanent incapacity can be given?

.....

.....

.....

Date Medical Practitioner

I hereby declare that the above statements and particulars are true and correct to the best of my knowledge and belief.

Dated this day of20.....

Signature of insured

