PRIME INSURANCE
Rest assured. You're insured

PERSONAL ACCIDENT CLAIM FORM

(THE COMPANY DOES NOT ADMIT LIABILITY BY THE ISSUE OF THIS FORM)
CLAIMS HOTLINE – 0501447071 / 0501447063

POLICY NO: _____ CLAIM NO: _____

I give hereunder particulars of an accident I was involved in and shall be glad to furnish any further information you may require.

Date: _____ Signature: _____

PERSONAL DETAILS

1. Full Name: _____

2. Email Address: _____ Postal Address: _____

3. Occupation and age: _____

4. Amount Weekly Earning: _____

DETAILS OF ACCIDENT

5. Date and time of accident: _____

6. Place of Accident: _____

7. How did the accident occur?

_____

_____

_____

_____

8. Briefly state the type of injury sustained:

_____

_____

_____

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9. Which hospital did you report to immediately after the accident?

_____

10. When did you get back to your usual occupation after the accident?

_____

11. Give name(s) and address (es) of any two persons who witnessed the accident:

a. _____

b. _____

If the injury/ death resulted from a Road Traffic Accident please attach a Police report.

TO BE COMPLETED BY A MEDICAL OFFICER

1.When did you first see the injured? _____

2. Briefly state the injuries sustained by the claimant

_____

_____

_____

3. Tick the type of Disablement likely to be suffered by the injured.

a. Permanent Total Disablement b. Permanent Partial Disablement

c. Temporary Total Disablement d. Temporary Partial Disablement

4. For how long will the claimant be disabled?

From: _____ To: _____

5. What is the degree of disfigurement if any? _____

6. State your opinion on any residual injuries or likely future development

_____

_____

_____

Address of Hospital / Clinic

_____

_____

_____

Signature & Stamp of Medical Officer

_____