MINERVA RISK ADVISORS

GROUP PERSONAL ACCIDENT CLAIM FORM

Warning: Insurance fraud is a crime.

INSURED: ……..… POLICY NUMBER: ……

1. Name in full ……. …….. Date of Birth ……/……. / 20 ….
2. Full address ……...
3. Present occupations (in full) ……..
4. Date of Accident/Event …… Time …….
5. Give a full description of the Accident/event and where it happened, and also what you were doing at the time ……..…… ……
6. Give Name and Address of Witness ……..
7. If nature of event is illness, when was the illness first diagnosed and where …… ……
8.

How long have you been confined to hospital/ House?	Hospital	Your House
	From / / 20	From / / 20
	To / / 20	To / / 20

9. Describe the extent and duration of your illness……..... ……..
10. Have you been able since the Accident/illness to give attention to any portion of your business or occupation? If so, to what extent and from what date …….. ……..…….....
11. State if claiming or entitled to Compensation for Disablement/illness from any other policy or Society. If so, give particulars. ……
12. How much is the claim (attach medical bills) ……...……..

The Medical Report Form must in every case be filled in, and the questions FULLY answered and attached to the claim form

NB- If the insured is too ill to write, this Form must be filled up and signed by someone else "for and on his behalf"

Name ……Signature……. Date ……

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CERTIFICATE OF MEDICAL ATTENDANT
(To be furnished at the Insured's expense)

THE MEDICAL ATTENDANT OF THE CLAIMANT SHOULD READ THE NOTICE BELOW BEFORE FILLING UP THIS FORM.

Name of claimant …… Date of Birth ……/……/ 20….

Address …….

Occupation …… ……..

Nature and cause of injury ……..

If to eye or limb, state right of left ……

Whether the appearance of the injury is consistent with the account given of the accident ……..…..

……

Date on which you first attended claimant for this injury ……/……/ 20……

Has claimant been wholly prevented from attending to any portion of his business: if so how long?

……..

Is claimant suffering from any disease or illness apart from his injury? And is there any illness or circumstances which may tend to retard recovery? If so, give particulars …….

……..

Between what dates do you consider: - * Total disablement will last ……..……..

** Partial disablement will last ……..

Present condition ……..

Remarks ……...

……

……

……

I hereby certify that the above-mentioned met with the accident referred to the, injuries he is suffering from are solely the result of the accident, and that the foregoing statements are correct.

Signature…… Address ……..

Qualifications ……. Date……/……/ 20….

* Temporary total disablement is described in the policy as such injury as shall disable and absolutely incapacitate the Insured from attending to any administrative and superintending duties.

** Temporary partial disablement is described in the policy as such injury as shall disable the Insured from attending to a substantial portion of his administrative and superintending duties.

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