REGENCY ALLIANCE INSURANCE PLC

RC. 223946

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CLAIM NO

PERSONAL ACCIDENT CLAIM FORM

This form should be completed and returned within seven days.
It is necessary that the questions overleaf be answered by a medical practitioner.
The Company does not admit liability by the issue of this form.

Name in Full…… Age…… Years
Private address …… Tel. No ……
Business address…….. Tel. No ……..
Profession or occupation……
Policy No…… Date of payment of last premium……

1. State when and where the Accident took place: *It occurred at*……*a.m/p.m on* ……..19……*at*……..
2. State how it happened and what you were doing at the time: *The fullest particulars should be given*
   ……
   ……
3. State, as precisely as you can, what injuries you have sustained ……..
   ……
4. Give name and address of the Doctor attending you for said injuries ……..
   Is he your usual Medical Attendant? ……..
   Had any other medical man been consulted? ……..
5. Have you been totally unable to attend to your business or occupation?……
   If so, state period during which you were totally disabled. From the …… to the …….. inclusive
6. Are you still totally unable to attend to your business or occupation? ……..
   If not, on what date were you able to attend to:
   (a) A portion of your occupation?…….. (b) The whole of your usual occupation ……
7. When and where can be visited by the Medical or other officer of the Company?……..
   ……
8. Are you entitled to claim under any other Insurance?……..
   If so, give particulars ……
9. Have you ever claimed compensation from any Accident Company? ……..
   If so, state name of Company, amount and date received ……

DECLARATION

I do hereby solemnly and sincerely declare that the foregoing statements and particulars are true, and that I will not abstain from, and have not abstained from following my usual occupation, either totally or partially, for a long period than necessary.

Date…… *Signature of Claimant*……

MEDICAL CERTIFICATE

The Claimant must obtain, at his own expense, the following Certificate from a dully qualified and registered Medical practitioner.

1. Name of patient in full……..
2. When did you first attend upon the Claimant in consequence of the injuries sustained?.....
3. Are you still in attendance?.....
4. Are you his usual Medical Attendant?..... *If so, how long have you known him?*.....
5. What was the cause of the Accident, so far as known to you?.....
6. What injuries were sustained…….
   (a) Regions injured……
   (b) Nature and extent of injuries……
   (c) Are the symptoms from which he suffers due to (i) *The Accident alone* ……
   Or (ii) *are they traceable to any other cause?*.....
7. Is he now or as he as the time of the Accident, subject to or suffering from any illness or disease irrespective of his injuries? …….
   If so, state the nature of same, and to what extent his recovery may be affected thereby ……..
   ……
8. Are you aware of anything in his previous medical history which might have contributed, directly or indirectly, to the occurrence of the Accident, or which may be likely to retard in any way his recovery from it?.....
9. Is he now, or has he been at any time since the date of the Accident totally *disabled from attending to his business or occupation? ……
   If so, give the dates: From……. To……
10. If he has been able to attend to a *portion only* of his usual business or occupation, please state when, and also the probable date of recovery……..
11. If the Claimant has recovered, please state date of recovery …….
12. General remarks…….
    ……
    ……
    ……
    ……
    Assessment of permanent Disability is ……%.....
    Signature…… Qualification……

***TEMPORARY TOTAL DISABLEMENT** occurs when through accidental bodily injury the Claimant is directly and wholly incapacitated from engaging in, or giving attention to, his usual business or occupation.*

***TEMPORARY PARTIAL DISABLEMENT** arises when the injury received does not wholly prevent the Assured from attending to business, or when Total Disablement ceases and he can attend to some portion of his usual business or occupation, but not the whole.*