General Insurance Co. Ltd.

PERSONAL ACCIDENT CLAIM FORM

(If the Claimant is unable to complete this Form, it may be filled in on his behalf)

Policy Number: **Period of Policy:** **Sum Insured:**

Name of Assured: **Address:**

Name of Claimant in FULL: **Tel:**

Present Business or Occupation: **Date of Birth:**

1. State time, date and place of Accident	**When**…… **Where**……..
2. Give a full description of the Accident and the circumstances surrounding it (on a separate sheet if necessary)	
3. State, as precisely as you can, what injuries you have sustained	
4. Have you any previous histroy of injury similar to that now sustained? **If so, give full particulars (on a separate sheet if necessary)**	
5. As a result of this accident, have you been unable to attend to any part of your business or occupation? **If the answer in 'Yes',** **(i) are you still so incapacitated** **(ii) between which dates have you been incapacitated?**	**(i)** **(ii)**
6. Are you claiming under any other policy in respect of this accident? **If so, please give full details**	

IMPORTANT: The Doctor's Medical Report on the reverse of this form must be completed and the whole form returned as soon as possible.

DECLARATION

I certify that the above particulars are correct in every respect.

SIGNATURE: **DATE:**

Please ensure that every question on this form is answered.

P.T.O.