

ACCIDENT / SICKNESS CLAIM FORM

Policy No

Name of Broker

Insured / Insured Person

Name of Insured

Address
Post Code Tel No.

Date of Birth

Present Occupation

Name of Claimant

Address
Post Code

Telephone Number Home Business

Date of Birth

Gross annual income

Present Occupation

Accident (to be completed for accident claims only)

Place accident occurred

Date accident occurred

Describe fully what happened and nature of injuries

Sickness (to be completed for sickness claims only)

State nature of Sickness

Date of Onset

General

Date ceased working

Have you since been able to give any attention whatever to any part of your business/occupation YES / NO
If yes, from what date

Have you resumed working YES / NO
If yes, from what date

Are you insured against accident or sickness with any other company YES / NO
If yes, give name and amount of benefit

Have you previously suffered from :

the cause of your present disability YES / NO
If yes, give details of dates and period of incapacity

any other injury or sickness YES / NO
If yes, give details of dates and period of incapacity

Do you suffer from any other physical defect or infirmity YES / NO
If yes, give details

Please state the name and address of your usual Doctor
Post Code

Declaration

I declare that the statements made on this form are accurate and complete to the best of my knowledge and belief and agree to authorise any doctor whom I have consulted to furnish Insurers with any information concerning my past physical or mental health and present condition.

Signature

Date