# PERSONAL ACCIDENT CLAIM FORM

Fidelity INSURANCE

## 1. INSURED PERSON

Name of Insured _____ Occupation _____

Address _____ Amount of Weekly Income _____

## 2. ACCIDENT

(a) Where did the accident happen ? _____

(b) The date and hour of accident __ /___ /_____

(c ) Describe fully how the accident happened? _____

_____

(d) If road accident has the matter been reported to police and details thereof? _____

_____

## 3. INJURIES

Describe fully the nature of injuries sustained _____

_____

4. Name/Names of Witnesses _____

_____

5. Were you at the time of the accident under the influence of drinks or drugs? _____

6. (a) Have you ever sustained injuries in any previous accident? _____

(b) If so please give details _____

7. (a) Have you been able to attend to your normal occupation since the accident? _____

(b) If not how long have you been disabled _____

8. (a) Name of the Doctors attending to your injuries _____

(b) Name of the hospital at which treatment was administered to you also whether in or out patient

_____

9. **Other Insurances.** Were you at the time of accident insured against accidents of this nature by any other

Insurance Company? _____

***I hereby warrant that the above statements and particulars are true and correct in every detail.***

Signature of Insured: _____ Date: __ /___ /_____

***NOTE: Doctors Certificate on reverse of this form must be completed.***

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## DOCTOR'S CERTIFICATE

1. Name of patient _____

2. When did he first consult you about this injury __ /___ /_____

3. State nature of Injury _____

_____

4. What was the cause? _____

5. Is he totally incapacitated from attending to any part of his occupation? _____

(a) Date of commencement __ /___ /_____

(b) Probable duration from date of this certificate _____

(c) If total incapacity has cased, date of cessation __ /___ /_____

6. Is he only partially incapacitated in the sense that he is unable to attend to a substantial and essential part of his occupation? _____

(a) Date of commencement __ /___ /_____

(b) Probable duration from date of this certificate _____

(c) If partial incapacity has ceased, date of cessation __ /___ /_____

7. Is he on your advice confined to the house or hospital? _____

8. General remarks _____

_____

Signature _____

Qualifications _____

Address _____

Date __ /___ /_____