CIC GENERAL INSURANCE LTD.

PERSONAL ACCIDENT CLAIM FORM

CIC GROUP

Claim No: _____ **Policy No:** _____

Employer's Name: _____

Postal Address: _____ Code: _____ Town: _____

Name: _____

Postal Address: _____ Code: _____ Town: _____

Age: _____ Years Tel No: _____ Mobile: _____

Occupation: _____

Date of Payment of Last Premium: _____

Date of Accident: _____ Time: _____ AM: ☐ PM: ☐

Place: _____

1. How did the Accident happen? _____

What were you doing at the time? _____

2. What injuries have you sustained? _____

3. Has the same part been injured previously? Yes: ☐ No: ☐

4. How long have you been totally or partially disabled from engaging in or attending to your usual business as the result of the injuries?
Totally From: _____ To: _____

Partially From: _____ To: _____

5. How long have you been confined to: Bed? ☐ House: ☐

From: _____ To: _____

From: _____ To: _____

6. Name and address of Doctors who is attending you: _____

Is he your usual Doctor? Yes: ☐ No: ☐

7. Have you required medical or surgical treatment during the past five years? Yes: ☐ No: ☐
If so, give details

_____

_____

8. Name and address of any witness of the Accident: _____

9. Are you claiming under any other insurance? Yes: ☐ No: ☐
if so, give details

_____

I WARRANT that the statements and particulars overleaf are correct and complete

Date: _____ Signature: _____

This from should be completed and returned within seven days
It is necessary that the questions here be answered by a registered medical practitioner.

Medical Certificate

Name of Patient: _____

What injuries has the patient sustained? _____

When were you first consulted? _____

How long has the patient been totally or partially disabled from engaging in or attending to usual business as the result of solely of the injuries?

Totally From: _____ To: _____

Partially From: _____ To: _____

How much longer do you consider such disablement will continue?

Totally From: _____ To: _____

Partially From: _____ To: _____

Does the patient have any disease or any physical defect and if so, of what nature?

_____

_____

To what extent may recovery be affected thereby? _____

Signature: _____ Date: _____

Qualifications: _____

Postal Address: _____ Code: _____ Town: _____

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