GOLDSTAR INSURANCE COMPANY LTD

Issue of this form is not to be taken as admission of liability

PERSONAL ACCIDENT/ WORKERS COMPENSATION CLAIM FORM

INSURED: …… POLICY NUMBER: …….

Date sent to Claimant: …….. Date Received from Claimant: ……..

DECLARATION OF ACCIDENT

1. Name in full Age next Birthday

2. Full address

3. Present occupations (in full)

4. Policy Number

5. Date of Accident 6. Time of day 'o' clock in the ……

7. Give a dull description of the Accident…….

and where it happened, and also what ……..

you were doing at the time ……..

8. Give Name and Address of Witness……..

……..

9. State, as precisely as you can, what injuries you have sustained

10.	How long have you been confined to the hospital, or House? If not confined to either, state the fact.	Hospital From…… To……	Your House? From…….. to……..

11.	Describe the extent and duration of your Disability……	Totally 'Disabled for……days from…… to …… Total ……..	Probable further duration of Disability (if any)

12. Have you been able since the Accident to give attention to any portion of your business or occupation? ……If so, to what extent and from what date?

13. State if you are claiming or been entitled to Compensation for Disablement from any other policy or Society. If so, give particulars.

14. What are you now prepared to accept in full ……..……. Day's Total Disablement settlement of the claim? …… Day's Partial Disablement

* It is necessary that this Form should be filled up minutely as possible to give an exact idea of the nature and extent of the Injury, and returned to the nearest branch within seven days

The Medical Report Form must in every case be filled in, and the questions FULLY answered and attached to the claim form

NB- If the insured is too ill to write, this Form must be filled up and signed by someone else "for and on his behalf"

The Claim form should be fully completed

Signature……

Date ……