

GOLDSTAR INSURANCE CO. LTD
Personal Accident Claim Form
(WITHOUT PREJUDICE)

To avoid delay and unnecessary correspondence in the processing of your claim, please observe the following requirements: -			
1. Ensure that both the claim form and the medical certificate are properly completed.			
2. Supporting documents or copies thereof plus original medical bills incurred, if any, must be submitted with the claim form			
Claimant's name in full			
Address			
Present Occupation		Present Age	
Policy No		Date of payment of last premium	
1 (a) Date of Accident?		1 (a) Time O'clock M	
(b) Where did it occur?		(b)	
© Describe fully how it happened		©	
Give name, occupation & address of a witness to the accident		Name	
		Occupation	
		Address	
2 (a) Describe the nature and extent of injuries you have received		2 (a)	
(b) Give names and addresses of the doctors who have attended to you for these injuries		(b) Names	
		Address	
3 (a) State the number of days you have been ENTIRELY confined to your bed, room, or house		(a) To bed for days from to	
		To room for days from to	
		To house for days from to	
(b) If you are still confined to you bed, room or house, state which			
4(a) State the extent and duration of your inability to attend to your business or occupation		I have been disabled	
		PARTIALLY for days from to	
		WHOLLY for days from to	
		I am now disabled (Insert "wholly" "partially" or "not at all")	
(b) If still disabled state how much longer the disability is likely to continue			
5. Have ever since the accident personally directed or supervised or given any attention whatever to your business or occupation? If so give particulars and dates			
6. (a) Are you entitled to receive compensation from any other company or other source? If so give particulars		6(a)	
(b) Have you ever claimed compensation from any company? If so, give particulars		(b)	
7. Are you perfectly free from any Physical Defect, Infirmary or Disease?			
DECLARATION			
I the undersigned, hereby declare that I am the person referred to in the above statement, which is true in every respect, and made without reservation.			
I hereby authorise the company to apply to my Medical Attendant mentioned above, for a report to be furnished at my expense in the form used by the company for the purpose			
Date		Signed	
NOTE: The Medical Certificate must be completed by your doctor before this claim form is forwarded to the company			

-MEDICAL CERTIFICATE

In order to establish his claim, the claimant must obtain and forward to the company a certificate from a duly qualified and registered medical practitioner and it is essential that this form be filled up as minutely as possible

The Medical Attendant of the claimant is requested to state: -			
1) Name & Occupation of the claimant:			
2) The exact nature and extent of injuries caused by the accident. If hand or arm, a foot or leg. State whether it is the Right or Left			
Regions Injured		Nature and extent of	
3. Whether the claimant has suffered or is now suffering from any constitutional or local disease or physical infirmity. If so state the nature of such disease or infirmity and to what extent it affects the disablement			
4(a). When and where he first attended the claimant		4(a) at	
		At O'clock M	
(b) Are you still attending to him?		On the day of	
5 To what extent the above accidental injuries have necessarily disabled the claimant from giving attention to his business	The claimant has been disabled	Claimant is now *.....disabled	The further disability (if any) will in my opinion continue For.....entirely For.....partially From the present time
	TOTALLY for days	*Insert totally, partially or not at all as the case may be.	
	PARTIALLY for days		
Total disablement arises when the claimant is rendered completely incapable of attending to any part of his ordinary professions, business or occupation. Partial Disablement arises when claimant is a little injured, or has so far recovered from injuries as to be capable of attending to some portion pf his ordinary profession, business or occupation			
6 (a) If the claimant is now in any way, attending to business, on what day he first commenced doing so after the accident.			
(b) If not whether you consider the claimant fit personally to supervise or direct his business or occupation			
7. Have you any reason to think that the patient was not perfectly sober at the time of accident?			
8. Is there any information, professional or otherwise that you consider should be known to the company?			
REMARKS: If any			
I certify that I have satisfied myself by personal examination that the Claimant has sustained an accident causing Injuries as above described			
Signature.....Qualifications.....			
Date.....Address.....			