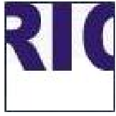


Reliance Insurance Company Limited

181-A, Sindhi Muslim Co-operative Housing Society, Karachi
Tel: 92-21-3-4539415-17 Fax: 92-21-3-4539412 Email: claim@relianceins.com

PERSONAL ACCIDENT CLAIM FORM

This form is issued without admission of liability, and must be completed and returned within seven days after its receipt. No claim be admitted unless a medical certificate overleaf is furnished at the expense of the Claimant.

Present Agent:

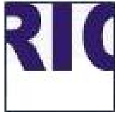
1. Name in full ______________________________
   Residence ______________________________
   Business Address ________________________
   Present Business or occupation
   If more than one state all

___________ Years.
Height
___________ ft. __________in
Weight
___________ st. __________lbs.

2. (a) When did accident occur? State day date and hour (b) Where did it occur? (c) Give full particulars of the cause and the Injuries sustained.	
3. Give names and address of any witnesses of the Accident	
4. (a) Give name and address of the doctor who Attended you (b) Name and address of your Ordinary Medical attendant	
5. State where and when a Medical or other officer of the company can visit you if necessary	
6. (a) State the number of days you have been necessary and entirely confined to bed room or house as the sole and direct result of the injuries sustained (b) If still confirmed to any, state which. (c) Have you in any way attended to business or work during the above period?	To Bed. To Room To House for ……. Days for _____days for _____days From ________ From ________ From ________ To ________ to __________ to __________ (both inclusive) (both inclusive) (both inclusive) ____ (b) (c)
7. Have you previously claimed or received compensation under an accident and/or sickness Policy? If so please give particulars.	
8. (a) Are you insured elsewhere? (b) If so give the name of such company or Insurer and amount you are entitled to claim…………..	(a) (b)

I Herby declare that I have received the injuries above described and warrant the truth of the foregoing particulars in every respect and I agree that if I have mad or if I shall make any false or untrue statement, suppression or concealment, my right to compensation shall be absolutely forfeited.

I claim to be paid the sum of _________________ per week, or the total sum ________________ which I agree to accept in full statement of my claim on the company



Reliance Insurance Company Limited

181-A, Sindhi Muslim Co-operative Housing Society, Karachi
Tel: 92-21-3-4539415-17 Fax: 92-21-3-4539412 Email: claim@relianceins.com

Private and Confidential — Medical Report

Policy No. ____________________ Claim No. __________________

NOTE:- the form to be completed by the claimant's medical Attendant whose replies should be as full as possible.

1. CLAIMANT – Name in full	
2. The nature and extent of injuries (if to a limb, state whatever right or left)	
3. The cause of the accident so far as known to you	
4. (a) Date of your first attendance upon him in consequence of the injuries sustained (b) Are you still in attendance?	
5. Are you his usual Medial Attendant and if so how long have you known him and for what have you attend him?	
6. (a) Are his symptoms (i) due exclusively to the Accident or (ii) traceable to disease infirmity or Any other cause? .... (b) Has he ever sufiered from gout. Rheumatism, Diabetes or fits? (c) Is there anything in his Medical history which may have contributed, directly or indirectly to the Accident or which may be likely to retard his recovery? (d) Have you any reason to suppose that he was under the influence of intoxicants at the time of the accident	(a) (b) (c) (d)
7. State the time <u>within your knowledge</u> that the claimant has Been as the direct and sole consequence of the injuries sustained <u>necessarily confined</u> to his bed, if still so confined state to which: and the probable duration of confinement to each…………..	**<u>TO BED</u>** From ………. To ………… (both in inclusive) **<u>TO ROOM</u>** From …………. To …………… (both in inclusive) **<u>TO HOUSE</u>** From ……….. To …………. (both in inclusive)
8. (a) Has been able to attend t o any portion of his business or occupation? (b) If so from what date?......... (c) If not please state probable date (i) of his being so able ……. (ii) of his complete recovery	(a) (b) (i) (ii)
9. Is there any disability? If not give date of recovery	
10. Any further remarks	

I hereby certify that the above-named with accident referred to, and that the foregoing statements are correct.

Signature _______________________ Qualifications__________________
Address ________________________ Date _____________20_______

TOTAL DISABLEMENT occurs when the insured is wholly prevented from attending to his business or occupation partial disablement when prevented from attending to a <u>substantial</u> portion thereof