PERSONAL ACCIDENT INSURANCE CLAIM FORM (PARTICULARS OF ACCIDENT)

الأهـلـيـة
AL AHLIA
PART OF THE RSA GROUP

TO BE COMPLETED BY THE INSURED

1. a) Name of insured (in full): ______________________________

   b) Name of the injured person: ______________________________

   c) Address in full: ______________________________

   d) Profession or occupation: ____________________ Age (last birthday): __________

2.

Policy No.	Sum Insured	Table of Cover	Period
(i)			
(ii)			
(iii)			

3. a) Date of accident: ______________________________

   b) Time of accident: ______________________________

   c) Where it happened?: ______________________________

   d) Name and address of the witness: ______________________________

4. How did the accident occur?: ______________________________

   ____

5. Injury received (If to the limb or eye, state whether right or left) ______________________________

6. a) Nature of disablement: ______________________________

   b) Extent of disablement: ______________________________

   c) Confined to bed?: ______________________________

   d) Confined to house?: ______________________________

   e) Present state of incapacity: ______________________________

7. Name and address of surgeon in attendance: ______________________________

8. a) Where and when can a medical officer of the Company visit you, if necessary?: ______________________________

   b) Name of nearest railway station and distance there from: ______________________________

9. a) Are you insured in any other or offices granting compensation for accident: ______________________________

   b) If so, state name and address of company or companies and amount of insurance: ______________________________

I hereby declare that the foregoing statements are made and are true in all respects and that I have not attempted to conceal from the Company anything which it ought to be made acquainted and also that I have not abstained from any usual occupation longer than absolutely necessary and I agree that if I have made, or further declaration the Company may require, shall make any false or fraudulent statement or any suppression, concealment or untrue averment whatever, the policy shall be void any and my right to compensation forfeited and am willing , if required to make a statutory declaration before a justice of the piece of the truth of the whole of the foregoing statement or any other statement I may make in connection with this claim.

Witness Name: ______________________________ Signature of the Insured: ______________________________

Witness Signature: ______________________________ Date: ______________

Witness Address: ______________________________

Date signed: ______________________________