GHANA UNION ASSURANCE COMPANY LIMITED

CLAIM NO……...

PERSONAL ACCIDENT CLAIM FORM

Name…… Age:……. Years :……..

Private address :…….. Tel. No. ……..

Business address : ……... Tel. No. ……..

Profession or occupation :……..

Policy No :…….. Date of Payment of last Premium :…….

1 State when and where the Accident took place : It occurred : …… a.m. / p. m. on

……

2 State how it happened and what you were doing at the time : The fullest particulars should be given ……..

……

……

3 Names and Addresses of any Witnesses ……

4 State, as precisely as you can, what injuries you have sustained ……..

5 Give name and address of the doctor attending to you for said injuries ……

Is he your usual doctor? ……..

Has any other doctor been consulted? ……

6 Have you been totally unable to attend to your usual business or occupation ? ……..

If so, state period during which you were totally disabled. From the …… to the ……inclusive

7 Are you still totally unable to attend to your usual business or occupation ?…….……

If not, on what date were you able to attend to : ……..

(a) A portion of your usual occupation ? ……(b) the whole of your usual occupation ? ……..

8 When and where can you be seen by an Official of the Company ? ……..…

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9 Are you entitled to claim under any other Insurance ? ……

If so, give particulars ……..……

DECLARATION

I declare that the foregoing statements and particulars are true, and I will not abstain / have not abstained from following my usual occupation, either totally or partially, for a longer period than necessary.

Date …….. Signature of Claimant ……

This form should be completed and returned as soon as practicable.

It is necessary that the questions overleaf be answered by a registered medical practitioner.

The Company does not admit liability by the issue of this form

MEDICAL CERTIFICATE

The Claimant must obtain, at his own expense, the following Certificate from a duly qualified and registered Medical Practitioner.

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1 When did you first attend to the Claimant in consequence of the injuries sustained ?.....

2 Are you still attending to him ?.....

3 Are you his usual Medical Doctor ?..... *If So, how long have you known him ?*.....

4 What was the cause of the Accident, so far as known to you ?.....

5 What injuries were sustained ?

Part of body injured ?.....

Nature and extent of injuries.....

Are there any symptoms not attributed to the accident ?.....

6 Is he now, or was he at the time of the Accident, subject to or suffering from any illness or disease irrespective of his injuries ?.....

If so, state the nature of same, and to what extent his recovery may be affected thereby.....

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7 Are you aware of anything in his previous medical history which might have contributed, directly or indirectly, to the occurrence of the Accident, or which may be likely to retard in anyway his recovery from it ?.....

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8 Is he now, or has he been at any time since the date of the Accident totally disabled from attending to his usual business or occupation ? .....

If so, give the dates : From ..... to.....

TEMPORARY TOTAL DISABLEMENT occurs when, through accidental bodily injury the Claimant is directly and wholly incapacitated from engaging in, or giving attention to his usual business or occupation.

9 If so disabled, please state your opinion as to the probable FUTURE duration of such disablement and probable date of his being able to resume some portion of his usual business or occupation .....

10 If he has been able to attend to a *portion only* of his usual business or occupation, please state since when, and also the probable date of recovery.....

TEMPORARY PARTIAL DISABLEMENT arises when the injury received does not wholly prevent the Claimant from attending to business, or when Total Disablement ceases and he can attend to some portion of his usual business or occupation, but not the whole.

11 If the Claimant has recovered, please state date of recovery.....

12 General Remarks.....

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SIGNATURE.....

ADDRESS.....

QUALIFICATION.....

DATE.....