ACROPOLIS INSURANCE BROKERS LTD.

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PERSONAL ACCIDENT CLAIM FORM.

To be completed by the insured and his/her doctor. Please return this document with 30 days of its receipt by the insured.

Name in full	
Age on next birthday	Present Occupation or Profession
Address:	
Telephone	Fax/EMail
When and where did the accident occur? Date: Time: Place:	
How did it happen? Provide full descriptions here	
Name and addresses of witnesses, if any	
Name and address of the doctor who attended you immediately after the accident	
Name and address of the doctor who is attending you now.	
Did the incapacity commence from the date of the accident? ☐ Yes ☐ No	If not, then when did it commence?
Are you entitled to compensation from any other company or club in respect of the injury for which you are claiming? ☐ Yes ☐ No If so, please provide full particulars	
When can a medical or other officer of the insurance company visit you if necessary?	

Medical Report. Any claim must be supported by a report below this form, from the Insured's Medical Attendant, any fee for the report being payable by the insured.

DECLARATION

The undersigned, hereby declares that I am the person referred to in the above statements, which are true in every respect and made without reservation and I hereby claim to be paid.

(a) Compensation at the rate of ______________ per week, as from the date ___________________ or

(b) the total sum of ___________________ which I agree to accept in settlement of any claim.

Delete (b) if the total claim cannot now be made, or (a) if total claim can be made.

Date: Signature & Stamp:

MEDICAL REPORT (to be completed by the doctor)	
Name of the Patient	
Describe fully the cause and circumstances of the accident as stated to you?	
Are the appearances of the injuries consistent therewith and do you believe they were caused as stated?	
Nature of the injury, please give detailed particulars	
On what date did the patient first consult you in connection with this accident?	
Are you the patient's usual medical attendant? If so, how long have you known him/her?	
Is the patient suffering from any injury or disease irrespective of that stated above? If so, please state nature of the same and to what extent the recovery may be affected thereby?	
Is the patient on your advice:- Confined to Bed? □ Yes □ No Confined to house? □ Yes □ No Able to get out of doors? □ Yes □ No	 From ____________ to ____________ From ____________ to ____________ From ____________ to ____________
If the patient is in your opinion unable to give any attention to his profession or occupation, please state:- (a) Date of commencement of total disablement (b) Probable duration from this date	 ____________________ ____________________
If disability has terminated, please state date of termination.	
General Remarks	
I certify that to the best of my belief the foregoing statements are correct:- Name ____________________ Qualifications ____________________ Signature ____________________ Date ____________________ Address ____	