

# Personal Accident Claim Form



NIG Commercial Claims P O Box 1151 Bromley BR1 9WB

Please note - you can complete this form on screen. When completing please use the tab and arrow keys to move between the relevant fields. Ensure you do not use the return or enter keys.

If completing by hand, please answer all questions using BLOCK CAPITALS.

## 1 You the Policyholder

Name of the Insured	<input type="text"/>		
Address	<input type="text"/>		
Town	<input type="text"/>	County	<input type="text"/>
Postcode	<input type="text"/>	Date Premium Paid	<input type="text"/>
Telephone Number	<input type="text"/>	Policy Number	<input type="text"/>
Value Added Tax. Are you a registered person or company?			Yes <input type="checkbox"/> No <input type="checkbox"/>
Age	<input type="text"/>	Height	<input type="text"/>
		Weight	<input type="text"/>

## 2 Circumstances of the Claim

<p><b>a</b> Occupation (please state all if more than one)</p> <input type="text"/> Brief description of job content i.e. usual duties and responsibilities <input type="text"/>	<p><b>e</b> Brief history of all previous illness/accidents including any earlier incapacity as a result of present condition. Please give approximate dates</p> <input type="text"/>
<p><b>b</b> Are you self employed? Yes <input type="checkbox"/> No <input type="checkbox"/> If <b>yes</b>, give particulars of clerical or supervisory duties</p> <input type="text"/>	<p><b>f</b> When were you first medically treated for present condition?</p> <input type="text"/>
<p><b>c</b> Name and address of employers</p> <input type="text"/>	<p><b>g</b> Name and address of doctor in attendance</p> <input type="text"/>
<p><b>d</b> Nature of present incapacity</p> <input type="text"/>	<p>If not your usual doctor also give his/her name and address</p> <input type="text"/>

## 2 Circumstances of the Claim *continued*

**h** State if totally or partially disable and give details.

Note: Total disablement arises when a claimant is continuously unable to attend to any part of usual occupation

**i** Totally

from  to

**ii** Partially

from  to

**i** Has incapacity confined you to

**i** Bed

from  to

**ii** House

from  to

**j** Give date of return or expected return to work

(dd/mm/yyyy)

**k** Are you claiming under any other policy? Yes  No

If **yes**, state name of insurance company and policy no.

## 3 Accident Report

**a** Date (dd/mm/yyyy)

Time

am  pm

**b** Place

**c** State activity/occupation actually engaged in at time of the accident

**d** If taking part in organised sport state:

**i** amateur or professional capacity

**ii** name of Club/Team you were representing

**e** Please describe accident

I declare that the answers given are to the best of my knowledge and belief true and comply in all aspects. I have no objection to the Company approaching the doctor for a full report on my present condition or previous medical history.

Signature

Date (dd/mm/yyyy)

Please ask for the doctors co-operation in completing the medical report below which must be returned as soon as possible after accident, whether or not fully recovered

## 4 Medical Report (to be completed by Doctor)

**a** Where and when did you first attend Patient in consequences of present incapacity?

**b** Describe nature of present condition/injuries

**c** If incapacity is the result of an accident are the injuries solely and directly attributable to and consistent with accident described by the patient?

**d** Have you previously treated the patients for the present conditions?

Yes  No

If **yes**, please give brief details

**4 Medical Report (to be completed by Doctor)** *continued*

**e** Are you aware of anything in patient's previous history which may contribute or prolong present incapacity? If so please advise details

**f** Please state period during which unable to attend to any part of usual duties or occupation (dd/mm/yyyy)

From  to

**g** Probable further duration

**h** Please state period during which able to attend to some part if not all usual duties or occupation (dd/mm/yyyy)

From  to

**i** Probable further duration

**j** Date of return or expected return to work

(dd/mm/yyyy)

**k** Remarks

Signature

Date (dd/mm/yyyy)

Address

