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Personal Accident And Sickness Claim Form

Please answer questions, but if any are inapplicable, please write 'Not Applicable'

Name of Insured: ______________________ Policy No. ______________

Name of Claimant (in full): ______________________ Date of Birth ______________

Address: ______________________ Tel No. ______________

Present Business or Occupation: ______________________ Email ______________

Date your employment commenced with your current employer: ______________________

ANSWER THESE QUESTIONS IF CLAIM IS FOR ACCIDENT	Have you ever suffered from this complaint before? YES ☐ NO ☐ If so, when? ______________ On what date did symptoms first appear? ______________
ANSWER THESE QUESTIONS IF CLAIM IS FOR ACCIDENT	How did the accident occur and what were you doing at that time? ______________ Date of accident ______________ Time ______________ Place ______________ Witnesses' names and addresses ______________

State as fully as possible what injuries you have suffered or the nature of your sickness:

____

Date Doctor first consulted ______________ Is he/she your usual Medical Attendant? YES ☐ NO ☐

Name and address of your usual Medical Attendant: ______________________

Has any other Doctor/Specialist been consulted? YES ☐ NO ☐ If YES, please give name and address

Name: ______________ Address: ______________

During what period have you been confined to hospital
as an in-patient or an out-patient? From: __________ To: __________ (inclusive)

Hospital name and address: ______________________

When were you able to attend: (a) To a PORTION of your usual Business or Occupation? (date) ______________

(b) To the WHOLE of your usual Business or Occupation? (date) ______________

Is any other Insurer paying you compensation for this accident or sickness ? YES ☐ NO ☐

If YES, which Insurer?

Are you receiving Social Welfare Benefit? YES ☐ NO ☐

If YES, please confirm the exact amount ______________

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I hereby declare that the above statements are true in every respect and are made without reservation, and I claim to be paid benefit under the policy, and also authorise any Medical Practitioner who has attended me to disclose to AIG Europe S.A., if required to do so, any or all information in respect of any medical or surgical condition from which I have suffered. A photostatic copy of this authorisation shall be considered as effective and valid as the original.

Date: ______________ Signature: ______________________

THE ISSUE OF THIS FORM DOES NOT CONSTITUTE AN ADMISSION OF LIABILITY UNDER THE POLICY.

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Medical Certificate

This Certificate will be completed at the expense of the Claimant

1. a. Are you the Claimant's usual Medical Attendant? YES ☐ NO ☐

b. How long have you known the Claimant?

c. Are you still in attendance? YES ☐ NO ☐

d. Date of first attendance for this present injury/illness ______________________

2. Accident Details:-

a. What was the DATE and Cause of the accident as far as you know?

b. What injuries were sustained? (If a hand, arm, foot or leg please state right or left)

c. Treatment

3. Sickness Details:-

a. Full details of illness ______________________

____

b. Diagnosis ______________________

____

c. Treatment ______________________

4. Is there anything in the medical history which might have contributed to the occurrence of the accident or illness, or which may in any way retard recovery?

5. Have any of the conditions referred to above left any effect upon the Claimant's constitution? If so, has the Claimant any knowledge of the nature of the complaint?

6. a. During what period has the Claimant been TOTALLY disabled from attending to any portion of his NORMAL duties?

From ______________________ To ______________________ (inclusive)

b. If Claimant is still totally disabled, please state probable date of PARTIAL resumption of his NORMAL duties

____

c. If Claimant is PARTIALLY disabled, please state from when and probable date of COMPLETE recovery

From ______________________ To ______________________ (inclusive)

d. If Claimant has recovered please state date of recovery ______________________

7. General Remarks

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I certify that these particulars are true and correct.

Signature: ______________________ Qualifications: ______________________

Address: ______________________

______________________ Date: ______________________

STAMP

V1.3 122018

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