MAYFAIR INSURANCE COMPANY LIMITED
8TH FLOOR MAYFAIR CENTRE, RALPH BUNCHE ROAD
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PERSONAL ACCIDENT CLAIM FORM

Policy No. P.A ……..

Claim No……

Important Notice: - The issue of this form is not to be taken as an admission of liability.

FORM TO BE COMPLETED BY THE INSURED

1. (a) Name of insured (in full) _____

   (b) Address in full _____

   (c) Profession or occupation _____ (d) Age of last birthday _____

2. (a) No. of policy _____(b) Date of Policy _____(c) Date of last payment of premium _____

3. (a) Date and time when accident occurred_____ on the _____day of_____

   (date) (month)

   _____ 20 _____ at _____ O'clock in the _____

   (b) Where it happened _____

   (c) Name and address of Witness _____

4. How did the accident occur? _____

5. Nature of injury received: _____

6. (a) Nature of disablement _____

   (b) Extent of disablement _____

   Confined to house from _____ to _____ Partial disablement from_____ to _____

   (c) Present state of incapacity _____

7. Name and Address of Surgeon or Doctor 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 therefrom _____

9. (a) Are you insured in any other office or Offices granting compensation for accident?

(b) If so name and address of Company or Companies and amount of insurance.

_____

10. If you are claiming for Temporary Total Disablement, does your weekly income immediately before accident exceed 50% the total weekly compensation you receive now from and all other sources? _____

_____

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

Signature of claimant: _____

Date: _____

Witness: _____

Address _____

CERTIFICATE TO BE FILLED UP AND SIGNED BY EYE WITNESS OF THE ACCIDENT.

I hereby certify that I was present when the Accident occurred to Mr._____

_____on the _____day of _____ 20 _____ in the

manner stated by him overleaf, that it*was caused by

was not caused

his willful act, and that he was not under the influence of intoxication liquor at the time.

Signature: _____

Name: _____

Address: _____

_____

Occupation: _____

Date: _____

*Strike out which is not applicable