REGENCY ALLIANCE INSURANCE LIMITED

GROUP PERSONAL ACCIDENT CLAIM FORM

CLAIM NUMBER:..... POLICY NUMBER: .....

THE COMPANY DOES NOT ADMIT LIABILITY BY THE ISSUE OF THIS FORM

INSURED'S NAME:.....

ADDRESS: .....

BUSINESS:..... OR OCCUPATION:..... TELEPHONE NUMBER:.....

DESIGNATION:..... AGE:.....

DATE OF ACCIDENT:.....TIME:.....PLACE:.....

1. How did the accident happen and What was injured person/deceased doing at the time?.....
   .....
   .....
   .....
2. Please give the names and addresses of any witnesses of the accident:.....
   .....
   .....
3. What Injuries were sustained?.....
   .....
4. (a) What is the name and address of the doctor who attended to injured person/deceased? .....
   .....
   (b) Is he the usual doctor?.....
5. How long has injured person/deceased been temporarily totally disabled and have not been able to go work?
   From:.....To:.....
6. Has injured person/deceased required medical or surgical treatment during the past five years? if so, please give particulars:.....
   .....
   .....
7. (a) Are you claiming under any other policy for this accident ? .....
   (b) if so, please give particulars :.....
   .....

DECLARATION

We declare that the above answers are true and complete

Date:.....2011 Insured's Signature:.....

(P. T. O. FOR MEDICAL CERTIFICATE)

MEDICAL CERTIFICATE

NOTE: THIS CERTIFICATE IS TO BE COMPLETED BY A DULY QUALIFIED AND REGISTERED MEDICAL PRACTITIONER AT THE INSURED'S EXPENSE

1. Name of patient:.....

2. What are his injuries?.....
.....
.....
.....

3. When did you first attend to him? .....
(a) Has the patient any disease, disability or physical defect apart from the effects of this accident?
If so, please give details: .....
.....
.....
(b) If he has, to what extent:
(i) Was the accident attributable to it? .....
(ii) Is recovery retarded by it? .....

4. State how long the patient has been temporarily totally disabled and for which period you gave him permission (Excuse Duty) to stay out of work. From:.....To:.....

5. Date patient was declared fit for work: .....

6. Please state the percentage residual incapacity resulting from the accident:.....

Signature:.....

Qualifications:.....

Address:.....

Date:.....2013