CG | UNITED

PERSONAL ACCIDENT CLAIM FORM

CLAIM NO. _____

Please print clearly in BLOCK LETTERS throughout. Answer all questions, selecting the necessary check box as appropriate and indicating Not Applicable if necessary. Date format is DD/MM/YY.

Branch or Agent _____ VAT No. _____

Policy No. _____ Account No. _____

This Form is issued without admission of Liability and must be completed and returned within seven days after its receipt. No Claim can be admitted unless the MEDICAL CERTIFICATE OVERLEAF is furnished at the expense of the Claimant.

SECTION 1 DETAILS OF INSURED

Name in Full _____ Tel No. _____

Email _____ Cell No. _____

Date of Birth _____ Height _____ ft. _____ in. Weight _____ lbs.

Residence Address _____

Business Address _____

Present address or occupation _____

(If more than one, state all) _____

Address where breakage occured _____

Noting the definition below, please select which of the following is applicable to you:

☐ Politically Exposed Person (PEP) ☐ Related to a Politically Exposed Person (PEP) ☐ Not Applicable

*A **Politically Exposed Person** (PEP) is one who has been entrusted with prominent public functions, for example a head of state or of government, senior politicians, senior government, judicial or military officials, senior executives of state-owned corporations, important political party officials. This category also includes immediate family members close personal and professional associates.*

SECTION 2 DETAILS OF CLAIM

1. (a) When did accident occur? State date and time	
(b) Where did it occur?	
(c) Give full particulars of the cause and the injuries sustained	
2. Provide Name, tel. nos. and address of each witness	
3. (a) Give name and address of Doctor who attended you	
(b) Name and address of your ordinary General Practioner	
4. (a) State where and when a Medical or other Officer of the Company can visit you, if necessary	

5. (a) State this period during which you have been totally disabled from attending to your business as the sole and direct result of the accident	From To
(b) Are you disabled? If No, from what date were you able to attend to some part of your business?	☐ Yes ☐ No From:
6. (a) Have you previously received compensation under an Accident and/or Sickness Policy? If Yes, please give particulars	☐ Yes ☐ No
8. (a) Are you insured elsewhere? (b) If Yes, give the name of each Company or Insurer, and amount you are entitled to claim	☐ Yes ☐ No

SECTION 3 DECLARATION

I HEREBY DECLARE that I have received the injuries above described, and warrant truth of the foregoing particulars in every respect, and I agree that if I have made if I shall make, any false or untrue statement, suppression or concealment my right to compensation shall be absolutely forfeited.

Signature of Insured _____ Date _____