multisure
INSURANCE BROKERS
your risk. we've got it.

STATED BENEFITS CLAIM FORM

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(TO BE COMPLETED AND SIGNED BY CLAIMANT)

Insured Name		Policy Number	
Insured Address		Contact Number	
Agent Name & No		Agent Reference	

PARTICULARS OF CLAIM

Full name of injured person.

Full address of injured person

Occupation of injured person

Age

State amount of salary or wages paid to the injured person during the twelve months prior to the accident.

When did the accident occur? Date

Time

AM

PM

Where did the accident occur?

How did the accident occur? (Full description)

Did the accident occur while the injured person was engaged in and upon your business?

YES

NO

Describe injuries

Name & address of doctor attending to injured person

Date injured person ceased work

When do you expect him to resume work?

State whether he is fully or partially incapacitated from work

DECLARATION

I/we warrant and declare that the particulars given above are true in every respect and that I/we have not withheld any information whatsoever in connection with the claim.

SIGNATURE OF POLICYHOLDER

Date

This form should be completed fully without delay and forwarded to the Company at one of the above addresses or your broker / agent, together with a certificate from the injured person's doctor. The issue of this form does not imply an admission of liability.

DOCTOR'S CERTIFICATE

Name of patient

When did he first consult you about this accident?

Are you still in attendance? YES NO

Are you his usual doctor? YES NO

State nature of injury and how sustained.

Is his condition due solely to the accident? YES NO

State whether his condition is complicated by illness or disease and whether he has any physical infirmity.

Is he totally incapacitated from attending to any part of his occupation? YES NO

Date of commencement

Probable duration from date of this certificate

If total incapacity has ceased, date of cessation.

Is he only partially incapacitated in the sense that he is unable to attend to a substantial and essential part of his occupation? YES NO

Date of commencement

Probable duration from date of this certificate

If partial incapacity has ceased, date of cessation.

Is he on your advice to the house or hospital?

General remarks

Signature Date

Qualification(s)

Address