



PERSONAL ACCIDENT INSURANCE CLAIM FORM

Claim No

Policy No

Name of Insured & Address:

Name of Injured Employee:

Nationality: Age: Salary:per Month

Description of Accident:

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Place of Accident: Date: Time: AM PM

Nature & Extent of Injury:

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Duration of Disablement:

Name of other person(s) involved in the accident:

Name of witness to the accident:

Details of Treatment received and where:

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Has the injured resumed his work after completion of Treatment & the date of resumption:

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Signature /Stamp of the Insured

FOR OFFICE USE			
TTD Period	From:	To:	No. of Days:
TTD Benefits	Amount:	Calculation:	
PPD Benefits	Percentage:	Amount:	Calculation:
Medical Expenses	Amount:		
TOTAL QRs.			