First Capital Insurance Limited
A member of the Fairfax Group

Company Reg. No. 195000106C
GST Reg. No. M2-0001676-9

Personal Accident Claim Form

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 a medical report be furnished at the expense of the Claimant.

1. Name in full: ______________________________ Age: __________
   Address (Private) ______________________________ Tel: __________
   (Business) ______________________________ Tel: __________
   Present Business or Occupation ______________________________
   If more than one, state all ______________________________
   Policy Number ______________________________

2. (a) When did accident occur? State day, date, and hour (b) Where did it occur? (c) Give full particulars of the cause, and the injuries sustained (d) Has the same part been injured previously?	
3. Give names and addresses of any Witnesses of the accident	
4. (a) Give name and address of the Doctor who attended to you (b) Name and address of your ordinary Medical Attendant	
5. State where and when a Medical or other Officer of the Insurer can visit you, if necessary	
6. What is the probable period of disablement?	
7. Please state:- (a) Whether you have been totally unable to attend to any portion of your business. If so, please give dates. (b) Whether you are still totally unable to attend to any of your business (c) On what dates you were able to attend (i) To a portion of your usual business or occupation (ii) To the whole of your usual business or occupation	(a) Yes/No From __________ To __________ (b) Yes/No (c) (i) (ii)
8. Please state whether in respect of the accident you are entitled to receive compensation from any other source. If so, from what source and to what extent?	
9. (a) Are you insured elsewhere? (b) If so, give the name of each Company or Insurer, and amount you are entitled to Claim (c) Please state full particulars	(a) (b) (c) Insurance Co Policy No Period of Insurance Amount Insured

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

Date ______________________ Signature of Insured ______________________

PRIVATE & CONFIDENTIAL

MEDICAL REPORT

NOTE: This form is to be completed by the Claimant's Medical Attendant whose replies should be as full as possible

1. CLAIMANT: Name in full ______________________________	
2. The nature and extend or injuries (If to a limb, state whether right or left)	
3. The cause of the accident, so far as known to you	
4. (a) Date of your firs attendance upon him in consequence of the injuries sustained (b) Are you still in attendance?	(a) (b)
5. Are you his usual Medical Attendant, and, if so how long have you known him, and for what have you attended to him?	
6. (a) Are the patient's symptoms:- (i) Due exclusively to the accident or (ii) Traceable to disease, infirmity or any other cause? (b) Is the patient now or was he at the time of the accident suffering from any illness, disease or infirmity? If so, state the nature and to what extent his recovery has been or may, be retarded thereby. (c) Have you any reason to suppose that he was under the influence of intoxicants at the time of the accident?	 (i) (ii) (b) (c)
7. Bearing in mind the patient's occupation and the two definitions below, please state:- (a) The period during which the patient has been totally and or partially disabled from attending to his usual business or occupation (b) The probable future duration of (i) total and/or (ii) partial disablement	Claimant has been temporarily disabled:- (a) Totally from ____________________to ________________ Partially from ____________________to ________________ (b) Totally from ____________________to ________________ Partially from ____________________to ________________
8. Has the patient sustained any permanent disability	
9. Is there any other information, professional or otherwise that you consider should be made known to us?	

I hereby certify that the above-named met with the accident referred to and that the foregoing statements are correct.

Signature ____ Qualifications ________________________

Address____ Date ___________________________

TEMPORARY TOTAL DISABLEMENT occurs when the Insured is wholly prevented from attending to his business or occupation

TEMPORARY PARTIAL DIABLEMENT occurs when the Insured is prevented from attending to a substantial portion thereof