

# Personal Accident Claim Form



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NIG is the trading name of The National Insurance and Guarantee Corporation Ltd  
Registered office: As above Registered in England and Wales number 42133

## 1 YOU THE POLICYHOLDER

PLEASE USE BLOCK CAPITALS

Name of Insured	<input type="text"/>		
Address	<input type="text"/>		
Town	<input type="text"/>	County	<input type="text"/>
Post Code	<input type="text"/>	Date Premium Paid	<input type="text"/>
Telephone No	<input type="text"/>		
Policy No	<input type="text"/>	Value Added Tax. Are you a registered person or company?	<input type="text"/>
Age	<input type="text"/>	Height	<input type="text"/>
		Weight	<input type="text"/>

## 2 CIRCUMSTANCES OF THE CLAIM

**a** Occupation (please state all if more than one)   
Brief description of job content i.e. usual duties and responsibilities

**b** Are you self employed? YES/NO   
If YES give particulars of clerical or supervisory duties

**c** Name and address of employers

**d** Nature of present incapacity

**e** Brief history of all previous illness/accidents including any earlier incapacity as a result of present condition. Please give approximate dates

**f** When were you first medically treated for present condition?

**g** Name and address of doctor in attendance  
  
If not your usual doctor also give his/her name and address

**h** State if totally or partially disable and give details. **Note:** Total disablement arises when a claimant is continuously unable to attend to any part of usual occupation

**i** Totally from  to

**ii** Partially from  to

**i** Has incapacity confined you to

**i** Bed from  to

**ii** House from  to

**j** Give date of return or expected return to work

**k** Are you claiming under any other policy? YES/NO   
If YES state name of insurance company and policy no

### 3 ACCIDENT REPORT

**a** Date and Time  **b** Place

**c** State activity/occupation actually engaged in at time of the accident

**d** If taking part in organised sport state

**i** Amateur of professional capacity

**ii** Name of Club/Team you were representing

**e** Please describe accident

I declare that the answers given are to the best of my knowledge and belief true and comply in all aspects. I have no objection to the Company approaching the doctor for a full report on my present condition or previous medical history.

Signature  Date


**PLEASE ASK FOR THE DOCTORS CO-OPERATION IN COMPLETING THE MEDICAL REPORT BELOW WHICH MUST BE RETURNED AS SOON AS POSSIBLE AFTER ACCIDENT, WHETHER OR NOT FULLY RECOVERED**

### 4 MEDICAL REPORT (TO BE COMPLETED BY DOCTOR)

**a** Where and when did you first attend Patient in consequences of present incapacity?

**b** Describe nature of present condition/injuries

**c** If incapacity is the result of an accident are the injuries solely and directly attributable to and consistent with accident described by the patient

**d** Have you previously treated the patients for the present conditions? **YES/NO**    
If **YES** please give brief details

**e** Are you aware of anything in patient's previous history which may contribute or prolong present incapacity - if so please advise details

**f** Please state period during which unable to attend to **any** part of usual duties or occupation From  to

**g** Probable further duration

**h** Please state period during which able to attend to some part if not all usual duties or occupation From  to

**i** Probable further duration

**j** Date of return or expected return to work

**k** Remarks

Signature  Date

Address