AUREOL INSURANCE COMPANY LIMITED

PERSONAL ACCIDENT CLAIM FORM

CLAIMS HELP LINE. 079 124 921
EMAIL: info@aureolinsurance.com

This Claim Form must be completed and returned to the Company within 14 days

The issue of this form is not to be taken as an Admission of liability.

CLAIM NO. ______________________________

SECTION I (TO BE FILLED IN FOR ALL CLAIMS)

1. (a) Insured's Name ______________________

(b) Address: ______________________ ______________________
______________________ ______________________

(C) Age: ______________________

2. (a) Policy No. ______________________ (b) Period From __________ to __________
(c) Issued at ______________________

3. (a) Particulars of accident: Date Time Place

Whether reported to Police Yes ( )No( ) (b) Details ______________________

4. (a) Were you removed to hospital immediately after the accident? Yes( ) No( )

(b) If yes, address of the hospital ______________________

5. (a) Do you have any other Group Personal Accident Policy? Yes ( ) No( )

(i) If yes, Name of the company: __________ (ii) Policy No.: ______________________ (iii) Period ____ yrs
from ________ to __________ (iv) Issued at: ______________________

(b) Are you entitled to recover medical expenses under this policy? Yes( ) No( )

If yes, (i) State Level of Medical Limit:

SECTION II (TO BE FILLED IN BY HOSPITAL AUTHORITIES)

1. Name and address of the hospital: ______________________
____

2. Date of admission: ______________________

3. Date of Discharge: ______________________

4. (a) Nature of injury: ______________________ (b) Particulars of treatment:
____

5. Has the accident resulted into loss of hand/s or foot/feet or eye/s permanent disability of any other type which may prevent the insured from engaging in or being occupied with or giving attention to any employment or occupation whatsoever? If yes, please give details

6. Hospital expenses (Please attach original bills)

State nature and extent of injuries

Disablement	From	To	Prognosis (Please indicate Probable duration of disablement
Confirm to house			
Unable to give attention to any Occupation			
Able to give some attention to his Occupation			

If Patient has now fully recovered, date of recovery

Dates and details of injuries from which he has previously suffered

I hereby certify having personally examined the above-mentioned Patient, that in my opinion the disability arises solely as a result of the accident described and that there are no other circumstances tending to produce either total or partial disability except

Signed.. Qualifications..

Address .... Date..

SECTION III (TO BE COMPLETED BY NOMINEE IN THE EVENT OF INSURED'S DEATH)

Details of Nominee

(a) Full Name: ____________________________ (b) Address:

____

____________________________ (c) Age:

____________________________ (d) Relationship with the deceased:

____

Date: ____________________________

Signature of the Nominee

Please attach or forward the following documents:

1. Death certificate
2. Post Mortem Report

Declaration to be signed by the Insured/Claimant or by a Nominee (in the event of insured's death)

I/WE HEREBY DECLARE and warrant the truth of the foregoing particulars in every respect. I/WE agree that if I/WE have made, or if, shall make false or untrue statement, suppression or concealment, my/our right to compensation shall be forfeited.

Date ______________ Signature ____________________