Heritage Insurance Company
A member of the LIBERTY Group

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# CLAIM FORM FOR PERSONAL ACCIDENT

Notes: If the claimant is too ill to write, this form should be completed by the responsible person in charge of him/her. No claim can be considered without the properly completed medical certificate overleaf, furnished at the expense of the claimant.

POLICY NO. : Date of Last Payment of premium :

## SECTION 1 - EMPLOYER DETAILS

1. Name of Employer
2. Contact Details: *(tel):* *(web):*
   *ID NO:* *PIN NO:*
   *(email):*
   *(postal):* *(code):* *(town/ city):*

## SECTION 2 - INJURED EMPLOYEE DETAILS

4. Injured Employee *Names:*
   *(mobile):* *(email):*
   *(postal):* *(code):* *(town/ city):*
5. (a) Occupation? (b) Age? (c) Married or Single?
   (d) Height? (e) Weight?

## IF ACCIDENT, PLEASE STATE ::

6. Date Time
7. Were you perfectly sober ? ☐ Yes ☐ No If "NO", give details :
8. Where did accident occur?
9. How did it happen and what were you doing at the time ?
10. Name and addresses of witnesses

| *Name* | *Tel. No. and Address* |
|---|---|
| | |
| | |
| | |

## THE INJURY / ILLNESS

11. Details of injury/illness
12. Have you previously suffered injury to the same part, or a similar illness ? ☐ Yes ☐ No
13. Date you were first totally incapacitated
    Date of doctor's first attendance
    Name of doctor first attending
    Who is your usual doctor?

14. For what previous injury or illness have you received medical attention? Please give full details with dates.

15. What occupations have you followed since the date of proposal for this insurance ?

16. Have you been prevented, on your doctor's advice, from engaging in work of any kind? ☐ Yes ☐ No
If YES, give dates and state "continuing" if necessary.

17. Are you now capable of any kind of work ? ☐ Yes ☐ No
If YES, what work and from what date ?

18. Are you now capable of full work? ☐ Yes ☐ No
If YES, from what date?

19. Are you entitled to claim compensation for this accident / illness from any other insurer? ☐ Yes ☐ No
If YES, give particulars

DECLARATION

I declare that the particulars upon this form are true and complete.

Date : _____ Signature : _____

(Rubber Stamp if Corporate)

# MEDICAL CERTIFICATE

THIS CERTIFICATE IS TO BE COMPLETED BY A DULY QUALIFIED AND REGISTERED MEDICAL PRACTITIONER AT THE INSURED'S EXPENSE
NB: BY TOTAL DISABLEMENT, IT IS UNDERSTOOD THAT THE CLAIMANT IS PREVENTED BY THE INJURY FROM ATTENDING TO ANY PORTION OF HIS DUTIES

1. Name of Patient?
2. When were you first consulted?
3. What injuries has the patient sustained ?
4. When and for what previous injuries and illness have you attended him ?
5. To what is the injury / illness directly attributable ?
6. If accident, have you reason to believe the claimant was not sober or was under the influence of drugs at the time? ☐ Yes ☐ No
   If "Yes", give details :
7. Is or was the claimant suffering from any other complaint which might have contributed to his present condition or might delay recovery? ☐ Yes ☐ No If so please give details :
8. For how long has the patient been totally incapable of any kind of work: FROM TO
9. For how long has the patient been partially incapable of any kind of work: FROM : TO
10. On the basis of the scale below, do you consider that the patient has suffered any permanent disability? ☐ Yes ☐ No
    If so, please indicate the percentage applicable

DECLARATION

Name of Medical Practitioner

Address

Qualifications

Date _____ Signature and Rubber Stamp _____

| *Injury* | *Scale of Permanent Disablement (%)* |
|---|---|
| Loss of both hands | 100% |
| Loss of both feet | 100% |
| Complete and irrecoverable loss of sight in both eyes | 100% |
| Loss of one hand and one foot | 100% |
| Loss of one hand or one foot together with the complete and irrecoverable loss of sight in one eye | 100% |
| Complete and incurable insanity | 100% |
| Complete and incurable paralysis | 100% |
| Loss of right arm or hand | 60% |
| Loss of left arm or hand | 50% |
| Loss of one leg or one foot | 50% |
| Complete and irrecoverable loss of sight in one eye | 50% |
| Loss of thumb of right hand | 20% |
| Loss of thumb of left hand | 15% |
| Loss of index finger of right hand | 15% |
| Loss of index finger of left hand | 10% |
| Loss of any other finger of right hand | 6% |

| *Injury* | *Disablement (%)* |
|---|---|
| Loss of any other finger of left hand | 5% |
| Loss of big toe | 5% |
| Loss of any other toe | 3% |
| Complete and irrecoverable loss of hearing in both ears | 40% |
| Complete and irrecoverable loss of hearing in one ear | 10% |

NOTE :

In the case of permanent disablement not specified in this table please assess in accordance with the degree of disablement by referring to the percentage indicated above without taking into account the occupation of the patient

1. In the event of the loss or loss of use of more than one of the aforementioned members or organ the percentages shall be aggregated but the total amount of the benefits payable shall in no case exceed 100% of the sum appropriate to the Insured person concerned written above..
2. When the limb or organ which was partially useless prior to an accident covered by this policy becomes completely useless as the result of such accident the amount payable shall be equal only to the loss of use occasioned by the accident. No payment shall be made in respect of the loss of a limb or organ which was useless prior to the accident.
3. When an Insured person is left handed the percentage above relating to the right hand shall apply to the left hand and vice versa.