FBC Insurance Company Limited

CLAIM No. .....

Please Return This Form To:

INJURY CLAIM FORM

ALL QUESTIONS MUST BE ANSWERED.

STAEMENT TO BE FURNISHED BY (OR ON BEHALF OF) INJURED PERSON

1. Name of Insured in full ..... Address ..... Occupation (describe fully)	Height ..... Weight ..... Age .....
2. How did the accident occur? (please state fully)	
3. When and where did the accident occur? ..... (a) Date ..... (b) Time ..... (c) Place	(a) (b) (c)
4. Who witnessed the occurrence?	
5. Nature of injuries	
6. Have you been totally and completely disabled as a result of the injuries received?	
7. When did (a) total disablement commence? ..... (b) confinement to the house commence?	(a) (b)
8. Are you at the present time (a) totally disabled? ..... (b) confined to the house? ...	(a) (b)
9. When do you anticipate being able (a) to leave the house (b) to resume at least part of your duties or attend to some portion of your business?	(a) (b)
10. Give name and address of the Doctor who attended you immediately after the accident	
11. (a) Who is your usual Medical Attendant? ..... (b) Have you consulted him in respect of your present injuries? ..... (c) When did you last consult him prior to this accident, and for what purpose?	(a) (b) (c)
12. Are you claiming under any other Policy or Policies in respect of this Accident? If so, state name of Company or Companies	
13. State Policy No.	

Dated this ..... day of ..... 19 .....

Signature .....

Address .....

PLEASE HAVE MEDICAL CERTIFICATE PRINTED OVERLEAF COMPLETED

MEDICAL CERTIFICATE

(TO BE FURINISHED AT THE EXPENSE OF THE INJURED PERSON)

Regarding the Injuries sustained by M.....

1. Are you the Insured's usual Medical Attendant?	
2. (a) When did you first see the Insured in respect of this Accident? . . . . . (b) Where did you then see him/her?	(a) (b)
3. Nature and extent of injuries	
4. Do the injuries seem consistent with the description of the accident given in answer to Question No.2 by the Insured?	
5. Is the Patient now, or was he/she at the time of accident suffering from or affected by any physical infirmity, disease or illness, irrespective of the injuries, or is he/she suffering from or has he/she suffered from any cardiac affection, gout, theumatism, or fits of any kind? If so give particulars	
6. When did you last see the Insured? . . . . . (b) Where did you then see him/her? . . . . . (c) Will you be seeing him/her again in respect of his/her present injuries?	(a) (b) (c)
7. Have you previously attended the Insured? If so, state for what purpose, with date or dates?	
8. Are you aware of anything in the previous medical history of the Insured which might have contributed to the accident or which is in any way likely to retard his/her recovery from it?	

Please see that only the Section (a) (b) (c) or (d) applicable to the case is completed)

9. (a) The Insured was totally disabled from the ..... to the ..... but was able to resume part of his/her duties on that date, and should be able to resume all his/her duties within the next ..... weeks, or

   (b) The Insured was and is still totally disabled, but should be able to resume part of his/her duties in about ..... week's time and partial disablement, should then cease in about ..... weeks, or

   (c) The Insured has not been totally disabled, but has not been able to attend to all his/her duties. He/She should, however, be able to do so within the next ..... weeks, or

   (d) The Insured has not been totally disabled, but was partially disabled from the ..... to the .....

I certify that I have examined the abovementioned person, and I have read the answers given by him/her to the questions on the previous page which appear to be in accordance with the present appearance of the injuries, and that there are no further cirumstances except ..... tending to produce total or partial disablement.

Dated this ..... day of ..... 19.....

Signature ..... Qualifications .....

Address .....