Orient Insurance Ltd (PB 4720)
Head Office 133, New Bullers Road, Colombo 04, Sri Lanka Tel (+94 11) 203 0300

PERSONAL ACCIDENT CLAIM FORM

IMPORTANT

1 Issuance of this form is not an admission of Liability or a waiver of the terms, conditions and exceptions of the insurance contract .
2 No claim will be admitted without ATTENDING PHYSICIAN STATEMENT Report as per format to be obtained at claimant's expense.

Claim No. **Policy No.**

1 PERSONAL DETAILS

NAME (In block letters):a)Insured ----------
:b)Claimant----------
Address ----------
City----------State----------
PIN----------
Occupation ----------
Age ----------

2 DETAILS OF ACCIDENT

Time and Date ----------
Place and Location (full address) ----------
.....
.....
Cause Description ----------

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3 DETAILS OF INJURIES

Specify Injured Parts of Body ----------

Total Disablement(if any) ----------
Percentage -------(%) ----------(In Words)

4 WITNESSES

i) Name .....
Address .....
.....
Phone No .....

ii) Name .....
Address .....
.....
Phone No .....

5 TREATMENT DETAILS

A Casualty Doctor
Name ----------
Address ----------
Phone ----------
Registration No ----------

B Family Doctor

Name ----------
Address ----------
Phone ----------
Registration No. ----------

C Hospital(s)

Name ----------
Address ----------
Phone No ----------

6 CONTACT DETAILS

Address where Available ----------
Phone No. ----------

(**Please be available at this place where our representative may call on you**)

7 CONFINEMENT

A Total Confinement From---------- To----------
(This should be the actual days when fully confined to bed on Medical Advice)
B Partial Confinement From---------- To----------
(This should be the days when partially confined to bed)

8 AMOUNT OF CLAIM

A Total Temporary Disablement Amount(Rs)----------
B Permanent Disablement Amount(Rs)----------
C Medical Expenses Amount(Rs)----------
D Death Amount(Rs)----------

9 PAST HISTORY

A Have you made any claims in the PAST ? YES/NO
B If YES, please give details including accident and Insurance details

10 Are you insured under any other policy ? YES/NO
If YES, please give full details

11 Have the Police Authorities been informed of this accident? YES/ NO
If YES, Case No …….. Police Station……

I hereby declare that I have suffered injuries as described above and all the details given are ABSOLUTELY **TRUE AND CORRECT**.I hereby agree to forfeit all my rights to compensation if any of the foregoing facts and /or details are found to be false or incorrect. I further authorise the hospital ,doctor diagnostic laboratory, organization, establishment or any other body or person dealt with in the course of this claim to give any information or document sought for by the Insurance Company.

Date:
Place:

Signature of the Insured

ATTENDING PHYSICIAN'S STATEMENT

PLEASE ANSWER ALL QUESTIONS

1 Name of Injured Person: _____
2 Age _____

3 Address _____
_____

4 Nature of the Accident and Details of Injuries Sustained. _____

5 Does the Cause of Accident as stated by the Claimant tally with the Injuries noticed by you? _____
6 Are the injuries solely due to the accident or traceable to any previous injuries/ disease/ infirmities ? _____
7 Was the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition. _____

8 Was the Claimant hospitalized? If so for what period? _____

9 What treatment was given and Operations performed? _____

10 Give all dates of treatment : Clinic/Hospital: From---------- ----To----------
Home :From----------To----------
11 Was he under the influence of intoxicants or drugs at the time of accident ? _____
12 Are you his usual medical Attendant ?
If you have treated him for any previous illness or injury , Please give details. _____
13 Have other Doctors been in Attendance or Consultation?
If yes, Please give details. _____

14 Has this accident been reported to the Police Authorities? If yes, Case No: _____ Police Station _____

15 Is this claimant Totally Disabled from each and every occupation? _____

16 (a) How long was or will the claimant be totally disabled from current occupation? From----- ---------- To----------
(b) How long was or will the claimant be partially disabled from current occupation? From---------- To----------
(c) Estimated date of return to Work. _____

17 What is the Prognosis? _____

Doctor's Signature **Date:** **Regn No:**

Doctors Name:
Address and Phone No.