Linkage Assurance Plc
RC:162306

PERSONAL ACCIDENT CLAIM FORM

Policy No P. A

Claim No

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

FORM TO BE COMPLETED BY THE INSURED

1. (a) Name of Insured (in full)
   (b) Address in full
   (c) Profession or Occupation (d) Age last birthday
2. (a) No. of Policy (b) Date of Policy (c) Date of last payment of Premium
3. (a) Date and time when accident occurred:. On the day of 20 at 0'clock in the
   (b) Where happened
   (c) Name and Address of witness
4. How did the accident occur?
5. Nature of Injury received:
   (a) to limb or eye, (state whether right or left)
6. Nature of disablement:
   (a) Extent of disablement
   (b) Confined to house from to Partial disablement from to
   (c) Present state or incapacity
7. Name and address of Surgeon in attendance
8. (a) Where and when can a Medical Officer of the Company visit you if necessary?
   (b) Name of nearest Busstop and distance there from
9. (a) Are you insured in any other Office or Offices
   Granting compensation for accidents?
   (b) If so, state name and address of company or
   Companies and amount of Insurance

I hereby declare that the foregoing statements are made by myself and are true in all respects and that I have not attempted to conceal from the Company anything with which it ought to be made acquainted, and also that I have not abstained from my usual occupation longer than absolutely necessary, and I agree that if I have made, or in any further declaration that the Company may require, shall make any false or fraudulent statement, or any suppression, concealment, or untrue avertment whatever, the Policy shall be void, and my right to compensation absolutely forfeited; and I am willing, if required, to make a Statutory Declaration before a Justice of the Peace of the truth of the whole foregoing statement or any other statement I may make in connection with this claim.

Witness: Signature of Claimant:

Address: Date:

Failure to complete this form in its entirely may result in a delay in processing this Claim

CERTIFICATE TO BE FILLED UP AND SIGNED BY AN EYE WITNESS OF THE ACCIDENT

I hereby certify that I was present when theAccident occurred to M

On the Day of 20 in the manner state by him overleaf, that it was caused by

which was/ was not his wilful act, and that he was not under the influence of intoxicating liquor at the time.

Signature

Address

Strike out which
Is not applicable

MEDICAL CERTIFICATE CLAIM MUST BE SUPPORTED BY MEDICAL EVIDENCE FURNISHED BY THE INSURED AND AT HIS EXPENSE

1. (a) Name of Claimant (b) Age

2. (a) Nature and cause of Accident
   (b) if to eye or limb, state left or right
   (c) Whether the appearance the injuries are consistent with the account given of the accident

3. Date on which you first attended Claimant for this injury

4. Has Claimant been totally prevented attending to any portion of his business? If so, how long?

5. is claimant suffering from any disease or illness apart from his injury and is there any illness or circumstance Which may tend to retared recovery? If so, give particulars.

Present condition.

6. How long from the happening of the Accident do you consider
   (a) Total disablement will last?
   (b) Partial disablement will last?

Having personally examined the above named Insured, I certify that the above statements are correct and that the injured person is necessarily disabled byAccident referred to

Signature Address:

Date:

REMARKS