Britam
With you every step of the way

PERSONAL ACCIDENT CLAIM FORM

Name of Insured ....

Address .... Phone No. ....

Occupation of the Injured person .... Age ....

Date of Accident .... Time .... a.m/pm Place ....

QUESTIONS	ANSWERS BY OR ON BEHALF OF THE INJURED PERSON
1.How did the accident happen? What were you doing at the time?	
2.What injuries have you sustained?	
3.Has the same part of your body been injured previously?	
4.How long have you been totally or partially disabled from engaging in or attending to your usual business as the result of the injuries?	Totally from.......................................To .... Partially from....................................To ....
5.How long have you been confirmed to:-	
(a) bed?	From.......................................To ....
(b) house?	From .... To..
6.Name and address of Doctor who is attending you. Is he your usual Doctor?	
7.Have you required medical or surgical treatment during the past five years? If so, give particulars.	
8.Names and addresses of any witness of the Accident	
9.Are you claiming under any other insurances? If so, give particulars.	

I WARRANT that the above statements and particulars are correct and complete

Date .... Name ....

Signature ....

This form should be completed and returned within seven days.

The questions overleaf should be answered by a registered medical practitioner.

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MEDICAL CERTIFICATE

(To be completed by a qualified medical practitioner)

1.Name of Patient	
2.What injuries has the Patient sustained?	
3.When were you first consulted?	
4.How long has the patient been totally or partially disabled from engaging in or attending to usual business as the result solely of the injuries?	Totally from ....to.. Partially from .... to ....
5.On the basis of the Permanent Disability Scale shown below, do you consider that the patient has suffered any permanent disability?	
6.If so, what is the percentage?..	
7.If the injury sustained by the patient is not specified in the Permanent Disability Scale, what percentage do you consider would be consistent with the percentages laid down in the Scale having regard to permanent loss or reduction in the earning capacity of the patient in any business or occupation?	
8.Has the patient any disease or any physical defect and if so of what nature?	
9.If so, has this aggravated in any way the present injury, and if so, what is the percentage of aggravation?	

Name of Medical Practitioner.. Signature..
Qualifications.. Address..
Date..

SCALE OF PERMANENT DISABLEMENT BENEFITS

Description of Disablement / Percentage Payable	Description of Disablement / Percentage Payable
Loss of or loss of Use of One arm hand leg or foot 100%	Loss of ring finger Three phalanges..8% Two phalanges ....6% One phalanx..3%
Complete and irrecoverable Loss of all sight in one or both eyes..100%	Loss of little finger Three phalanges.. 10% Two phalanges .... 6% One phalanx 3%
Loss of thumb Both phalanges.. 30% One phalanx 10%	Loss of toes All toes of one foot ....25% Great – both phalanges..5% Great – one phalanx..2% Any other toe 5%
Loss of index finger Three phalanges ....12% Two phalanges ....8 % One phalanx 4%	Loss of hearing Both ears..50% One ear 20%
Loss of middle finger Three phalanges 8% Two phalanges ....6% One phalanx 3%	

In the event of the loss or loss of use of more than of the aforementioned members or organs the percentage shall be aggregated but the total amount of Benefit payable shall in no case exceed 100% of the sum appropriate to the Insured Person concerned written above.
When a 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. When an Insured Person is left-handed the percentages above relating to the right hand shall apply to the left hand and vice versa.