GEMINIA INSURANCE COMPANY LIMITED
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GEMINIA INSURANCE CO.LTD.

PERSONAL ACCIDENT
CLAIM FORM

INSTRUCTIONS:
This printed form is forwarded on receipt of notice of an accident, and its issue to the policyholder is in no way an admission of liability. The form must be completed and returned to the company at the above address. Within 10 days of it being sent to the policyholder's last known address. The medical report must be returned as soon as possible by the medical practitioner, directly to the company at the above address.

Part 1: Policy-holder and the Insurance

1. Name_____

Profession, Business or Occupation_____

Insured Person's Age_____ Years, Height_____feet_____Inches Weight_____lbs

Residential Address_____Business Address_____

Name of address and business of the employer_____

2. Policy Number_____Renewal Date_____Date last premium paid _____

To whom was the premium paid_____ ☐ Cash ☐ Cheque

Part 2: Accident

3a) When did it occur? on the _____day of_____20 _____at _____o'clock in the _____

b) Where did it occur?_____

c) State how the accident was caused, and what you were doing at the time?_____

_____

d) i. If an accident injury arose out the use of a motor vehicle, for what purpose was it being used? ☐ Business ☐ Pleasure

ii. Name and address of Motor Insurers?_____

e) State as precisely as you can what injuries you have sustained _____

_____

If you sustained an injury on your eye, leg, arm, foot, or hand, please state whether it is the right or left

.4. Name and address of the doctor who attended to you for the injuries described.

Name_____

Address_____

Date disablement commenced_____

Describe the extent and duration of your disability	Total Disabled	Partially Disabled	Present state of Disability
	For_____days	For_____days	

Note: By Total disabled, its is understood that the claimant is prevented by the injury from attending to any business or occupation. Partially disabled is when the claimant is so slightly injured or has so far recovered, as to be able to transact some portion of business or occupation, but not the whole.

a. To what extent have you been able since the accident to attend to business and engage in any occupation?

_____

b. Are you, or have ever been insured against Personal Accident with another Insurance Company? ☐ Yes ☐ No

c. Have you ever made a claim or received any payment from this company or any Insurance Company? ☐ Yes ☐ No

If so state the number of claims_____ Total amount of Compensation_____Year or Years of Claim_____

Part 3 Declaration

I/We do hereby declare that to the best of my knowledge and belief that the statements set forth herein are true and complete. Further, no material facts have been missed or misrepresented. I/we agree that the proposal together with any other information supplied shall form the basis of any contract of insurance effected thereon.

Date_____ Signature_____