



# SRIC

Ensuring your tomorrow, today.

## PERSONAL ACCIDENT/STATED BENEFITS CLAIM FORM

### POLICY DETAILS

FAILURE TO FULLY ANSWER EVERY QUESTION MAY PREJUDICE ANY CLAIM

Claim Number

Policy Number

Full Name of Insured

Age

Private Address

Tel No.

Business Address

Tel No.

Email Address

Date of Accident

DD / MM / YYYY

Time

am

pm

1 How did the accident happen?  
State what you were doing at the time.

2 What injuries have you sustained?

3 Has the same part been injured previously?

Yes

No

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

DD / MM / YYYY

to

DD / MM / YYYY

Partially from

DD / MM / YYYY

to

DD / MM / YYYY

5 How long have you been confined to:

Bed?

From

DD / MM / YYYY

to

DD / MM / YYYY

House?

From

DD / MM / YYYY

to

DD / MM / YYYY

6 Name and address of doctor who is attending to you.  
Is he/she your usual doctor?

Yes

No



7 Have you required medical or surgical treatment during the past five years? If so, give particulars.

Yes  No

Two horizontal yellow bars for providing details.

8 Names and addresses of any witnesses of the accident.

Four horizontal yellow bars for providing witness information.

9 Are you claiming under any other insurance? If so, give particulars.

Yes  No

One horizontal yellow bar for providing insurance details.

I warrant that the above statements and particulars are correct and completed.

Date

Signature

This form should be completed and returned within seven days

IT IS NECESSARY THAT THE QUESTIONS ON THE OVERLEAF BE ANSWERED BY A REGISTERED MEDICAL PRACTITIONER



## MEDICAL CERTIFICATE

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 of the injuries?

Totally from

to

Partially from

to

How much longer do you consider such disablement will continue?

From

to

Partially from

to

5 Has the patient any disease or any physical defect and if so, of what nature?

  
  
  

To what extent may recovery be affected thereby?

  

Signature

Qualification

  

Address

Date