Personal Accident Claim Form

NIG Commercial Claims P O Box 1151 Bromley BR1 9WB

Please note - you can complete this form on screen. When completing please use the tab and arrow keys to move between the relevant fields. Ensure you do not use the return or enter keys.
If completing by hand, please answer all questions using BLOCK CAPITALS.

1 You the Policyholder

Name of the Insured

Address

Town

County

Postcode

Date Premium Paid

Telephone Number

Policy Number

Value Added Tax. Are you a registered person or company? Yes ☐ No ☐

Age

Height

Weight

2 Circumstances of the Claim

a Occupation (please state all if more than one)

Brief description of job content i.e. usual duties and responsibilities

b Are you self employed? Yes ☐ No ☐

If **yes**, give particulars of clerical or supervisory duties

c Name and address of employers

d Nature of present incapacity

e Brief history of all previous illness/accidents including any earlier incapacity as a result of present condition. Please give approximate dates

f When were you first medically treated for present condition?

g Name and address of doctor in attendance

If not your usual doctor also give his/her name and address

2 Circumstances of the Claim *continued*

h State if totally or partially disable and give details.
Note: Total disablement arises when a claimant is continuously unable to attend to any part of usual occupation

i Totally

from to

ii Partially

from to

i Has incapacity confined you to

i Bed

from to

ii House

from to

j Give date of return or expected return to work

(dd/mm/yyyy)

k Are you claiming under any other policy? Yes ☐ No ☐

If **yes**, state name of insurance company and policy no.

3 Accident Report

a Date (dd/mm/yyyy) Time

am pm

b Place

c State activity/occupation actually engaged in at time of the accident

d If taking part in organised sport state:

i amateur or professional capacity

ii name of Club/Team you were representing

e Please describe accident

I declare that the answers given are to the best of my knowledge and belief true and comply in all aspects. I have no objection to the Company approaching the doctor for a full report on my present condition or previous medical history.

Signature Date (dd/mm/yyyy)

Please ask for the doctors co-operation in completing the medical report below which must be returned as soon as possible after accident, whether or not fully recovered

4 Medical Report (to be completed by Doctor)

a Where and when did you first attend Patient in consequences of present incapacity?

b Describe nature of present condition/injuries

c If incapacity is the result of an accident are the injuries solely and directly attributable to and consistant with accident described by the patient?

d Have you previously treated the patients for the present conditions?

Yes ☐ No ☐

If **yes**, please give brief details

4 Medical Report (to be completed by Doctor) *continued*

e Are you aware of anything in patient's previous history which may contribute or prolong present incapacity? If so please advise details

f Please state period during which unable to attend to any part of usual duties or occupation (dd/mm/yyyy)

From to

g Probable further duration

h Please state period during which able to attend to some part if not all usual duties or occupation (dd/mm/yyyy)

From to

i Probable further duration

j Date of return or expected return to work

(dd/mm/yyyy)

k Remarks

Signature

Date (dd/mm/yyyy)

Address

NIG1112Q/06/15