Prime Asset Cover

The Policy that protects You - The Prime Asset in your business

FORM PA-A05-001

INJURY / ILLNESS CLAIM FORM

POLICY NUMBER: | TYPE:

BROKER / AGENT:

INSURED
- NAME
- BUSINESS
- VAT Reg. No. | TEL No.
- ADDRESS

INSURED PERSON
- NAME & AGE
- BUSINESS OR OCCUPATION

RELATIONSHIP OF INSURED PERSON TO INSURED
- IF EMPLOYEE GIVE ANNUAL EARNINGS DEFINED IN THE POLICY:
- IF OTHER — SPECIFY RELATIONSHIP:

INJURY / ILLNESS
- WHEN AND WHERE DID ACCIDENT OCCUR / ILLNESS COMMENCE — DATE: D D M M Y Y Y Y — TIME:
- GIVE FULL PARTICULARS OF THE ACCIDENT AND NATURE OF INJURIES OR THE NAME OF THE ILLNESS — PLACE:

WITNESS
- NAME AND ADDRESS

DOCTOR
NAME AND ADDRESS
- DOCTOR WHO ATTENDED YOU
- YOUR USUAL DOCTOR

DISABLEMENT
- PERIOD OF TEMPORARY TOTAL DISABLEMENT — FROM: D D M M Y Y Y Y — TO: D D M M Y Y Y Y
- PERIOD OF TEMPORARY PARTIAL DISABLEMENT — FROM: D D M M Y Y Y Y — TO: D D M M Y Y Y Y
- GIVE DATE NORMAL OCCUPATION RESUMED — DATE: D D M M Y Y Y Y
- HAS ANY PERMANENT DISABLEMENT RESULTED? — YES: Y NO: N *IF YES GIVE DETAILS ON SEPARATE CLAIM FORM*

OTHER INSURANCES
- GIVE NAME/S OF ANY OTHER INSURER WITH WHOM THE INSURED PERSON IS INSURED

PREVIOUS CLAIMS
- GIVE DETAILS OF ALL CLAIMS MADE AGAINST INSURERS OR IN TERMS OF COID BY THE INSURED PERSON

WAS INSURED TESTED FOR ALCOHOL OR DRUGS? YES: Y NO: N

IF YES, WAS INSURED UNDER THE INFLUENCE OF ALCOHOL OR DRUGS? YES: Y NO: N IF YES, GIVE DETAILS ON SEPARATE FORM.

DECLARATION / AUTHORISATION

I/We acknowledge the sharing of claims information by insurers is essential to enable the insurance industry to underwrite policies and assess risks fairly and to reduce the incidence of fraudulent claims. In the public interest and with a view to limiting premiums, I/We hereby waive any right to privacy in any insurance or claims information supplied by me or on my behalf in respect of any insurance application or claim made or lodged by me/us and I/We consent to such information being disclosed to any other insurance company or its agent. I/We also waive any rights to privacy and consent to the disclosure of any information to any insurance claim concerning me or any insured person I/We represent. I/We further declare all the particulars true in every respect and correct, and I/We understand that if any claim lodged under this policy be in any respect fraudulent or if any fraudulent means or devices be used by me/us or anyone acting on my/our behalf or with my/our knowledge or consent to obtain any benefit under this policy or if any event be occasioned by the wilful act or with the connivance of me/us, the benefit afforded under this policy in respect of such claim shall be forfeited.

Insured's Signature | Date: D D M M Y Y Y Y | Capacity

I hereby authorise any hospital, physician, or other person who has attended or examined me, to furnish to the company, or its authorised representative, all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostat copy of this authorisation shall be considered as effective and valid as the original.

Insured Person's Signature | Date: D D M M Y Y Y Y

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