PERSONAL ACCIDENT CLAIM FORM

Policy No: ……

Claim No: …… Date of Accident: ……

This form is issued without admission of Liability, and must be completed and returned within seven days after its receipt. No claim can be admitted unless the MEDICAL CERTIFICATE OVERLEAF be furnished at the expense of the claimant.

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1. POLICYHOLDER

Name in full: ……

Present Age: …… Height: …..……ft…….in Weight: ……st…….lbs

Residence: ……

Business Address: ……..

Present Occupation: ……...
(if more than one , state all.)

2. ACCIDENT

1. (a) When did accident occur? State day, date, and hour. (b) Where did it occur? (c) Give full particulars of the causes and the injuries sustained	
2. Give names and addresses of any witnesses of the accident	

Trident Insurance Financial Centre
Highway 7, Hastings, Christ Church, BB15154 Barbados W.I.
Telephone: (246) 431-2347 Fax: (246) 427-5750
E-Mail: trident@tridentins.com www.tridentins.com

3. INJURY AND GENERAL INFORMATION

1. (a) Give name and address of Doctor who attended you (b) Name and address of your ordinary Medical Attendant	
2. State where and when a Medical or other Officer of the Company can visit you, if necessary	
3. (a) State the period during which you have been totally disabled from attending to your business as the sole and direct result of the accident (b) Are you still totally disabled? If not, from what date were you able to attend to some part of your business?	
4. Have you previously claimed or received compensation under an Accident and/or Sickness Policy? If so, please give particulars	
5. Are you entitled to compensation from any other source for this accident ? If so, give particulars.	

I HEREBY DECLARE that I have received the injuries above described, and warrant the truth of the foregoing particulars in every respect, and I agree that if I have made, or if I shall make, any false or untrue statement, suppression or concealment my right to compensation shall be absolutely forfeited.

Signature: …… Date: ……

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MEDICAL CERTIFICATE

TO BE COMPLETED AND SIGNED BY THE INSURED PERSON'S MEDICAL ATTENDANT

Name of patient: _____ Age:_____

Profession or Occupation: _____

Are you the Patient's usual Doctor? _____ Period known to you: _____

Cause of incapacity: _____

Date patient first seen: _____

State nature and extent of injuries: _____

State as fully as possible the cause of the Accident: _____

_____

_____

_____

Is the appearance of the injury consistent therewith? _____

Disablement	From	To	Prognosis (Please indicate probable duration of disablement)
Confined to house			
Unable to give attention to any occupation			
Able to give some attention to his/her occupation			

If Patient has now fully recovered, date of recovery: _____

Dates and details of injuries from which he/she has previously suffered: _____

_____

_____

I hereby certify having personally examined the above-mentioned Patient, that in my opinion the disability arises solely as a result of the accident described and that there are no other circumstances tending to produce either total or partial disability.

Signed…… Qualifications……

Address…….. Date……..

The Fee (if any) for this Certificate to be paid by the Claimant

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