Guardian Group
Guardian General Insurance Limited

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PERSONAL ACCIDENT CLAIM FORM

EACH OF THESE QUESTIONS MUST BE ANSWERED COMPLETELY

N.B. BOTH CLAIM FORM AND DOCTOR'S CERTIFICATE TO BE COMPLETED AND RETURNED IMMEDIATELY

1. Policy Number _____ Claim No. _____

   Insured _____ Date of Birth: _____
   mm/dd/yy

   Home Address _____ Tel No: _____

   Business Address _____ Tel No: _____

   _____

   E-mail address: _____ Occupation: _____

2. The Accident Date _____ Time _____ a.m./p.m.
   mm/dd/yy

   Place _____

   Description _____

   Particulars of injuries _____

   _____

   _____

3. Names and addresses of Witnesses _____

   _____

   _____

4. (a) Name and address of doctor in attendance _____

   (b) Is he your usual doctor? _____

5. (a) How long have you been totally incapacitated from attending to your occupation? From _____ To _____
   mm/dd/yy mm/dd/yy

   (b) How long have you been partially incapacitated in the sense of being necessarily prevented from attending to a substantial and essential part of your occupation? From _____ To _____
   mm/dd/yy mm/dd/yy

6. Is there any other policy covering this loss?

   _____

   _____

   If so, please give particulars _____

   _____

   _____

Date: _____ Signature of Insured: _____

If the Insured is unable to attend to this form, it should be completed on his behalf.

P.T.O

DOCTOR'S CERTIFICATE

1. Name of Patient _____

2. When did he/she first consult you about this condition? _____

3. State condition from which patient is suffering _____

_____

_____

_____

4. Is this condition due to accident? _____

_____

5. Has he/she any illness or disease or physical infirmity apart from the condition mentioned above?
   If so, please give details and indicate whether it will retard recovery.

_____

_____

_____

_____

6. Is he/she **totally** incapacitated from attending to any part of his/her occupation? _____

   (a) Date of commencement _____

   (b) Probable duration from date of this certificate _____

   (c) If **total** incapacity has ceased, date of cessation _____

_____

7. Is he/she only **partially** incapacitated in the sense that he/she is unable to attend to a **substantial** and **essential part of his/her occupation**?

   (a) Date of commencement _____

   (b) Probable duration from date of this certificate _____

   (c) If partial incapacity has ceased, date of cessation _____

_____

8. Is he/she on your advice confined to the house or hospital? _____

_____

_____

9. General remarks: _____

_____

_____

Signature and Stamp _____

Qualifications _____

Address _____

_____

Date _____

mm/dd/yy