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KEY INSURANCE COMPANY LIMITED

Registered Office: 6c Half Way Tree Road, Kingston 5, Jamaica WI
Tel:926-6278/926-1720/929-7940-3/929-1218-9. Fax: 960-4063/929-7944
Web: www.keyinsurancejm.com. E-mail: info@keyinsurancejm.com **Toll Free: 1-888-CALL KEY (225-5539)**

Personal Accident Claim Form

The issue of this form is not to be taken as an admission of liability.
The completion and return of this form to the Company should not be delayed if any of the particulars required cannot be immediately given. They may be forwarded to the Company afterwards as soon as possible.

1. a) Name of Insured

   b) Address

2. Date and Time of Accident

3. DETAILS OF INJURED PERSON:

   Name: Home Address:

   Date of Birth: Business Address:

   Telephone Number: Present Business or Occupation:

   Nature of Injury: Height Weight

   TRN No.: Email:

   Source of Funds for Payment of Premium:

   Other

   Would you like to send/receive Communication Electronically ☐ Yes ☐ No

   Are you an EU Resident: ☐ Yes ☐ No

4. ACCIDENTS:

   State clearly how and where the accident occurred, with full details, including details of any defect (if any) which may have caused the accident:

5. INJURIES:

   What injuries did you sustain (If to limb or eye state whether right or left).

   Were you admitted to hospital or medically attended? ☐ Yes ☐ NO

   If so, give particulars including the name of the Hospital or Medical Facility:

CUSTOMER INFORMATION SHARING

I/we agree that Key Insurance may share any personal and financial information that I/we provide to Key Insurance with the current and future subsidiaries and affiliates of GraceKennedy Limited for the purposes of marketing other products and services offered by said subsidiaries and affiliates of GraceKennedy Limited.

Yes ☐ No ☐

DISABILITY:

I. Nature of disablement:

II. How Long have you been confined to your be or house?

III. Are you still confined to your bed or house? ☐ YES ☐ NO

If yes please give dates From: To:

From: To:

IV. To what extent have you been able to attend to business or engaged in any occupation since the accident

V. Wholly disabled FOR DAYS

Partially disabled FOR DAYS

Present state of disability:

VI. Name and address of Doctor /Surgeon attending you

8. Have you previously claimed or received compensation under and Accident and /or Sickness Policy? ☐ YES ☐ NO

If so , please give particulars

I/We, the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect; and I/We agree that if I/We have made, or in any further declaration the Company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited, and the Policy shall be null and void.

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Insured's Signature

Date

CERTIFIED TO BE FILLED UP AND SIGNED BY AN EYEWITNESS TO THE ACCIDENT

(IF APPLICABLE)

I hereby certify that I was present when the Accident occurred to Mr/Ms. on the

day of 20 in the manner stated by him over leaf, that it was caused by

which * was /was not his willful act and that he was /was not under the influence of intoxicating liquor at the time.

Date:

Signature:

Address:

Medical Certificate

(to be completed by your Doctor)

Name of claimant Sex Age

I certify that the above person was injured on the day of 20 . His / Her injuries are:

Caused by

If injuries are complicated by any other condition, please give details

He/she has been totally unable to work from the day of 20 to day of 20

and disablement is the direct and evident consequence of an accident to him/her, particulars of which are given above.

Date: Signature and Qualifications:

For Office use: POLICY NUMBER:

POLICY PERIOD: FROM TO

CLAIM NO:

KEY INSURANCE COMPANY LIMITED
6C Half Way Tree Road, Kingston 5, Jamaica WI
Telephone: 876-926-6278, 876-929-7940-3
Web: www.keyinsurancejm.com | Email: info@keyinsuranceja.com

EUROPEAN UNION CITIZEN/RESIDENT REQUIREMENT

On May 25, 2018, the European lawmakers passed a data protection bill termed General Data Protection Regulations (GDPR) that superseded all prior data protection regulations. The intent and purpose of GDPR is to empower European Union (EU) data subjects and the rights to their data. Each organisation is mandated to formulate and implement systems and controls to safeguard data, not abuse data, and empower data subjects to enforce their rights to their data. Some of these rights take the form of the following:

- Right to be forgotten: the data subject conditional to the laws of a country may request that their data be forgotten totally.
- Right of consent: no data must be processed without the consent of the data subject.
- Right to be notified: the data being processed must be clearly notified and this notification must be explicit
- Right to understand how each data subject's data is being processed: any EU client can make this request, and the business is mandated to respond and walk the client through the process.

DECLARATION

I/We the undersigned, do hereby declare and Warrant that:

1. The above statements are true
2. If any of the above statements and particulars are not in my/our handwriting the person or persons filling in such statements and particulars shall be deemed to be our Agent or Agents for the purpose of this Insurance.

I/We agree that this Declaration shall be held to be promissory, and that:

1. This Proposal shall be the basis of the contract between me/us and the Company
2. Within my/our knowledge there is no other material fact which should be disclosed

I/We further Warrant that the vehicle or vehicles to be Insured shall **NOT** be driven by any person who:

1. Is not Insured by this Policy
2. Is not permitted to drive by this policy
3. Is not permitted to drive by any Licensing Authority
4. Has had their license revoked or cancelled by any Licensing Authority

I/We also Agree to:

1. Accept a Policy of Insurance according this proposal and subject to the terms, exceptions and conditions usually prescribed by the Company for this Class of Risk.
2. To pay the premium due for this Insurance to the Company/Broker/Agent of the Company
3. To keep the vehicle in good condition (road worthy?)

Policy to commence on the day of 20 for month(s)

Proposer's Signature:

(IF PROPOSER IS UNABLE TO SIGN HIS NAME)

This is the Mark of he/she being unable to read or write. The above was read over to him/her and he/she signed same as true and correct

SIGNATURE OF WITNESS