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:

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:

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: