CENTURY INSURANCE COMPANY LIMITED

PERSONAL ACCIDENT CLAIM FORM

To be completed by the insured and his Doctor and returned within seven days of receipt by the insured.

1. Name of Insured in full _____

2. Policy Number_____Date of Payment of last Premium _____

3. Renewal Date _____Present address of Insured _____

_____

4. (a) Age next birthday _____

   (b) Present profession or occupation _____

5. If claim is in respect of bodily injury resulting from accident

   (a) When and where did the accident occur?

   Date _____ Time _____Place _____

   (b) How did it happen? (Full Description to be given) _____

   _____

   (c) Name and addresses of any withnesses of the accident _____

   _____

   (d) Name and address of Doctor who attended Insured immediately after the accident _____

   _____

   (e) Name and address of Doctor now attending insured _____

   _____

6. Is Insured entitled to compensation from any other company or any club in respect of the injury or disease for which he is claiming? If so, full particulars to be given _____

   _____

7. Where can a medical or other officer of the Company visit Insured if necessary ? _____

   _____

8. Nearest railway station and distance therefrom _____

Medical Report, any claim must be supported by a report on the reverse side of the form from the Insured's Medical Attendent, any fee for the report being payable by the Insured.

DECLARATION

I, the undersigned, hereby declare that I am the person reffered to in the above statements, which are true in every respect and made without reservation, and I hereby claim to be paid.

(a) compensation at the rate of _____per week, as from the _____or

(b) the total sum of _____ which I agree

to accept in settlement of my claim.

Date _____ ***Signature*** _____

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