Guardian Group
Guardian General Insurance Jamaica Limited

Kingston
19 Dominica Drive, P.O Box 401, Kingston, Jamaica
t: 876 926 3720 f: 876 929 2727

Montego Bay
Lot B15, Fairview II Shopping Centre
P.O. Box 170, Montego Bay, Jamaica, W.I.
t: 876 935 6661 f: 876 929 5256

PERSONAL ACCIDENT CLAIM FORM

INCORPORATED IN JAMAICA

Branch Policy No. Claim No.

This form should be completed and returned without delay.

The MEDICAL CERTIFICATE OVERLEAF is to be furnished at the expense of the Insured.

1. Name in full Telephone No.

   Residence

   Business Address

   Present Business or Occupation
   If more than one, state all

   Date of Birth TRN:

   Height Weight

2. (a) Date Time Place of accident

   (b) Give particulars of the cause, and the injuries sustained

3. Name of Witnesses of the accident

   Address of Witness of the accident

4. Name of the Doctor attending you?

   Address of the Doctor attending you?

5. State where and when a Medical or Other Officer of the Company can visit you, if necessary

6. (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.

   From To

   (b) Are you still totally disabled? ◯ Yes ◯ No

   If not, from what date were you able to attend to some part of your business? From

7. Have you previously claimed or received compensation under an Accident and/or Sickness Policy? ◯ Yes ◯ No

   If so, please give particulars

8. (a) Are you insured elsewhere? ◯ Yes ◯ No

(b) If so, give the name of each Company or Insurer, and amount you are entitled to claim

Company/Insurer _____ Entitled Amount _____

I, the undersigned, do hereby declare that, to the best of my knowledge and belief, the foregoing particulars are true and correct. I/We further declare that the statements above can be relied upon in the contemplation of litigation proceedings which may arise.

Date _____ Signature _____

PRIVATE AND CONFIDENTIAL

Medical Certificate to be completed by Insured's Doctor

I CERTIFY that _____

was injured on _____

His injuries are _____

Caused by _____

If his injuries are complicated by any other conditions, give details

_____

He is solely and directly _____ disabled as a result of the injuries and will be so disabled until _____

Signatures and Qualifications} _____

Total Disablement occurs when the Insured is *wholly* prevented from attending to his business or occupation;

Partial Disablement when prevented from attending to a *substantial* portion thereof.

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