INSURANCE COMPANY JAMAICA LIMITED

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PERSONAL ACCIDENT CLAIM

Date and Time of Accident			Policy No.	Renewal Date
Place Accident happened				

							FOR OFFICE USE
INSURED	Name						
	Address						
	Type of Business						
	Business Address						
	Tel Nos		(h)		(w)	(c)	
INJURED PARTY	Name		Address				
			Occupation				
	Tel Nos		(h)		(w)	(c)	
	Age		Height		Weight		

ACCIDENT	State how the Accident was caused and what you were doing at the time						
	Name of witness		Address				
		Tel Nos		(h)		(w)	(c)
INJURIES	What inuries have you sustained? (If to an eye, hand or arm, foor or leg, please state whether it is the right or left)						
DISABILITY	How long have you been confined to your bed or house?		Are you still confined to your bed or house?	☐ Yes	☐ No		
	To what extent have you been able to attend to business or engaged in any occupation since the accident?						
	Wholly disabled	Partially disabled	Present state of disability				
	For ___ days	For ___ days					
GENERAL	Name and Address of Doctor attending you						
	Is he/she your usual Medical Attendant?	☐ Yes	☐ No	If so, give particulars			

Date ______________________ Signature ________________________

MEDICAL CERTIFICATE *(to be completed by your Doctor)*

I CERTIFY THAT the above person is suffering from ____

and he/she has been totally unable to work from the _______ day of __________________ 20___________ and disablement is the direct and evident consequence of an accident to him/her, particulars of which are given above.

Date ___________________________ Qualification ____ Signature ____

The fee (*if any*) for this Certificate to be paid by the claimant

Revised July 7,2010