GUARDIAN LIFE LIMITED
LOOKING AFTER LIFE
A MEMBER OF THE GUARDIAN HOLDINGS GROUP

12 TRAFALGAR ROAD, KINGSTON 5, P.O. BOX 408

Employee Benefits Division
GROUP PERSONAL ACCIDENT CLAIM FORM
EBD 208

CLAIM FORM - GROUP PERSONAL ACCIDENT INSURANCE (NOTICE OF CLAIM must be given no later than 15 days following the accident or onset of illness). All Sections must be completed before claim is processed.

SECTION A

[1a]**GROUP POLICY #:**	[1b]**MEMBER #:**
COMPANY/PROPOSER:	
[3]**EMPLOYEE - FULL NAME (PLEASE PRINT)**	[2]**T.R.N:**
ADDRESS:	
DATE OF BIRTH: DD……...../MM……...………../YY…..………..	DATE DISABILITY BEGAN: DD……..…./MM……........../YY……..... ....
DATE OF ACCIDENT: DD…….......…/MM……....…../YY........…….…..	DATE LAST SEEN BY DOCTOR: DD…....../MM…........../YY....…… ....
DATE LAST ATTENDED WORK: DD...…../MM....../YY...…...	IS THIS YOUR FIRST CLAIM FOR DISABILITY? ☐ YES ☐ NO

WHEN DO YOU EXPECT TO RETURN TO WORK/OR WHEN DID YOU RETURN TO WORK?

DD……………………...……/MM………………………...….......…/YY………………………………...………………...

NATURE OF ACCIDENT/ILLNESS:

I certify that the above statements are correct and hereby authorize the Company, my Doctor/hospital to give Guardian Life or their Agents any additional information required in connection with this claim.

Employee Signature ______________________ Date ______________________

SECTION B
EMPLOYER'S CERTIFICATE
(must be fully completed)

I am the Employer of the above named Employee, and certify as follows: The above Employee was absent from work due to illness/accident

From..

To..

Signature ______________________ Date ______________________

Position Held in Company:.. Company's Stamp:

SECTION C

ATTENDING PHYSICIAN STATEMENT

[1a]**Group #:** _____ [1 b]**Member #:** _____ [2]**T.R.N:** _____

N.B.: **THE PATIENT IS RESPONSIBLE FOR COMPLETION OF THIS FORM WITHOUT EXPENSE TO GUARDIAN LIFE LIMITED**

[3]**NAME OF PATIENT/MEMBER:** _____

DATE OF BIRTH: _____

PRESENT
ADDRESS: _____.

1. HISTORY

(a) When did accident happen?/disability commence?: Day:_____Month_____ Year_____

(b) Date Employee ceased attending work because of accident/disability: Day_____ Month_____ Year : _____

(c) Has patient ever had same or similar condition? Yes: ☐ No: ☐ (If "Yes" state when and describe)

_____

_____

2. PRESENT CONDITION (Give details of Insured's present condition. Include results of X-Ray or Special Test)

(a) Is patient Ambulatory?_____ Bed confined:_____ House Confined: _____

Hospital confined:_____

3. DIAGNOSIS:_____

4. TREATMENT: _____

(a) Date of first visit: Day: _____ Month: _____ Year: _____

b) Date of last visit: Day: _____Month: _____ Year: _____

c) Frequency of visits: Weekly: ☐ Monthly: ☐ Other: ☐

(d) When did you last examine the patient? Day: _____ Month:_____Year _____

5. PROGRESS: Recovered: ☐ Improved: ☐ Unimproved: ☐ Retrogressed: ☐

6. EXTENT OF DISABILITY:

(a) Is disability temporary or permanent? _____

(b) Is disability total? Yes ☐ No ☐

[1a]**Group #:** _____ [1 b]**Member #:** _____ [2]**T.R.N:** _____

[3]**NAME OF PATIENT/MEMBER:**. _____

(c) If disability is not total, please explain: _____

_____

(d) Has Employee resumed work? If no, when do you think patient will be able to resume work? _____

Approximate Date: _____

If yes, when did Employee resume work? _____

(e) For loss of limb/organ:

Limb/Organ Lost: _____

(i) Nature of loss: _____

(ii) Percentage of loss: _____

(iii) Is loss permanent: _____

Any additional comment by attending physician:

_____

_____

_____

_____

_____

_____

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_____

_____

_____ _____

DATE ATTENDING PHYSICIAN

_____

ADDRESS STAMP

PERSONAL ACCIDENT CLAIM FORM
GUARDIAN LIFE LIMITED
FORM #: EBD.E 0024/00208; 03/2010

For Official Use: Index by Group Number, Member Number, TRN and Name of Member.
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