THE INSURANCE COMPANY OF THE WEST INDIES LIMITED

2 St. Lucia Avenue, Kingston 5, Tel: 926-9040-7, 926-9182-91, Fax: 929-6641

PERSONAL ACCIDENT CLAIM FORM

To be completed by the Insured and his/her Doctor and returned
within seven (7) days of its receipt by the Insured

I hereby declare that all particulars to be given are true and correct and that no false or fraudulent statement will be made _____
Insured's Signature

NOTE: "N/A" means "Not Applicable"

1. Policy No.	2. Source	3. Client No.

4. (a) Name in full _____ (b) Date of Birth _____

(c) Present Address _____

(d) Present Profession or Occupation: _____

(e) Email Address: _____

5. (a) When and where did the accident occur? (Date and Time) _____

Place: _____

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

_____

_____

(c) Name & addresses of any witnesses to the accident. _____

_____

_____

(d) Name & address of Doctor who attended you immediately after the accident. _____

_____

(e) Name & address of Doctor now attending you. _____

_____

6. (a) Did the incapacity commence from the date of the accident? _____

(b) If not when did it commence? _____

7. Average weekly wages _____

8. Are you entitled to compensation from any other Company or any Club in respect of the injury for which you are claiming? If so, full particulars to be given. _____

_____

_____

_____

9. Where can a Doctor or an Officer of the Company visit you if necessary? _____

_____

MEDICAL REPORT. Any claim must be supported by a report on the reverse side of this form from the Insured's Medical Attendant, any fee for the report being payable by the Insured.

DECLARATION

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

Delete (b) if total claim cannot now be made, or (a) if total claim can be made.

(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: _____

MEDICAL REPORT

(Any fee for this report is payable by the patient)

Name of Patient: _____

1. Describe fully the cause and circumstances of the accident as stated to you. _____

2. Are the appearances of the injuries consistent therewith and do you believe they were caused as stated? _____

3. Nature of injury - please give detailed particulars. _____

4. On what date did the patient first consult you in connection with the accident? _____

5. Are you the patient's usual Medical attendant? If so, how long have you known him/her? _____

6. Is the patient suffering from any injury or disease irrespective of that stated above? If so, please state nature of the same and to what extent recovery may be affected thereby. _____

7. Is the patient on your advice:-
   (a) Confined to bed? From: _____ To: _____
   (b) Confined to house? If so, please state probable duration of such confinement from this date. _____
   (c) Able to get out of doors? From: _____ To: _____

8. If the patient is in your opinion unable to give any attention to his profession or occupation, please state:-
   (a) Date of commencement of total disablement. _____
   (b) Probable duration from this date. _____

9. If the patient is in your opinion able to give partial attention to his profession or occupation, please state:-
   (a) Date of commencement of partial disablement. _____
   (b) Probable duration from this date. _____

10. If disability has terminated, please state date of termination. _____

11. General Remarks _____

I certify that to the best of my belief the foregoing statements are correct.

Signature: _____ Qualifications: _____

Address: _____ Date: _____