canopy health insurance

GROUP PERSONAL ACCIDENT CLAIM FORM

EMPLOYER'S STATEMENT

Employer/Policyholder

Policy Number

Address of Policyholder

Full Name of Insured

Insured's Tax Registration Number

Insured's Date of Birth (D D M M M Y Y)

Salary/Wage of insured (per month/per week)

Date of Accident (D D M M M Y Y)

Nature of Accident

Place of Accident

Date Insured Last Attended Work (D D M M M Y Y)

Date Insured returned to Work (D D M M M Y Y)

During the period, did the Insured receive any remuneration or benefits from the Employer? Yes No

Is this the First Claim in connection with this Accident? Yes No

Company Stamp

Name and Position of Employer Representative

Signature

Date

INSURED'S STATEMENT

Full Name of Insured

Insured's Tax Registration Number

Insured's Date of Birth (D D M M M Y Y)

Name of Employer

Occupation and Duties

Where did the Accident occur

How did the Accident occur

Describe bodily injuries sustained wholly from the Accident

INSURED'S STATEMENT (CONT'D)

D D M M M Y Y
Date Disability Started

D D M M M Y Y
Date you ceased performing occupational duties

Give details of Physicians seen regarding your current Accident (names, addresses, dates of service, diagnosis/treatment)

I certify that the above statements/responses are full and true to the best of my knowledge and understand that payments will be made in accordance with the terms and conditions of the Group Policy.
I hereby authorize my Employer to disclose full details of my duties, salary and terms of employment, to Canopy Insurance Limited. I further authorize and instruct all medical professionals and institutions to fully disclose to Canopy Insurance Limited or its duly appointed representative, all information relative to my health and medical history.

Signature of Employee | Witness | Date

ATTENDING PHYSICIAN'S STATEMENT

COMPLETION OF THIS FORM IS NOT AT THE EXPENSE OF CANOPY

Name of Patient

Patient Address

D D M M M Y Y
Patient Date of Birth

D D M M M Y Y
Date accident occurred/disability commenced?

D D M M M Y Y
Date Patient ceased attending work because of accident/disability

Has patient ever presented with the same or similar condition? If yes, please provide details

Is the patient ambulatory ☐ Confined to bed ☐ Confined to house ☐ Hospitalized ☐

Diagnosis

Treatment administered

Date of first visit D D M M M Y Y Frequency of visits: Weekly ☐ Monthly ☐ Other

Date of last visit D D M M M Y Y Has the patient Improved ☐ Recovered ☐ Retrogressed ☐

Is the disability temporary or permanent? Yes ☐ No ☐

Is the disability total? Yes ☐ No ☐

If the disability is not total, please explain

Has the employee returned to work? If not, give an indication as to when you believe that the patient will be able to resume work (in any occupation for which he is reasonably qualified)

LOSS OF LIMB/ORGAN

Limb/Organ lost

Nature/Degree of loss

Percentage of Loss

Is the loss permanent?

Please provide any additional information or comments

I hereby certify that the answers to the foregoing questions are accurate and complete to the best of my knowledge and belief.

Physician's signature

Date

Address

Stamp