PERSONAL ACCIDENT CLAIM FORM

PRINT RESET

MUA
Insuring the Individual.

Insured information

Policy number	Insured
Date:	
Home tel.	Bus tel.
Employer	
Occupation & duties	

Details of event

Describe accident:	
Date	Time
Place	
Describe the nature of the injuries:	

Witness

Name		Tel
Address		
Date	Time	Place
Name		Tel
Address		
Date	Time	Place
Name		Tel
Address		
Date	Time	Place

Kindly advise which benefit is being claimed for:

Disability Death Hospital

Are you making any other insurance claims as a result of the accident? Yes No

Name of company(ies) from which you are claiming:

Please fill in the attending doctor's details

Doctor's Name	Doctor's Telephone Number

Please fill in the Hospital's details (if applicable)

Hospital's Name	Hospital's Telephone Number

Please fill in the dates relating to the disability/hospitalisation

Totally disabled:	From (date):		To (date):	
Partially disabled:	From (date):		To (date):	
Confined to hospital:	From (date):		To (date):	

Authorisation

I hereby authorise any hospital, physician or other person who has attended to or examined me to furnish to the company, or its authorised representative, all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical reports or records. A photostat copy of this authorisation will be considered valid.

Processing Consent:

By making use of our services, products and service channels, I explicitly agree and consent that MUA may process my personal information (which includes special personal information) for the purposes as described in the Privacy and Security Policy. Please note that if you are acting on behalf of the proposer / policyholder in any capacity, by signing, you explicitly confirm that you have the written/recorded authority and/or mandate to act on their behalf.

Insured's signature: Date:

Medical Certificate

(To be completed by the attending Doctor)

Insured:

Policy no.:

1. When did you first attend to the patient as a result of this accident?

2. Are you the general medical practitioner of the patient?

3. What was the cause of the accident?

4. Parts of body injured and degree of injuries:

	Head	Chest	Neck	Abdomen	Back	Upper Limbs	Lower Limbs	Pelvis
Minor								
Fairly Severe								
Severe								
Other								

5. a) Provide full details of the nature of the injuries and any complications e.g. compound fracture, left disfigurement, etc.

5. b) State treatment given to date.

6. Do you have any reason to suspect that the patient was under the influence of alcohol and/or drugs?

7. a) Have the injuries aggravated any pre-existing pathological condition? Yes No

7. b) If the answer to 7 a) is Yes, please provide full details.

8. a) Is permanent disability expected? Yes No

8. b) If Yes, provide full details.

8. c) If No, has his/her condition stabilised?

9. Are you prepared to certify that the patient is totally and permanently disabled from attending to any portion of his/her occupation?

Medical Certificate

(To be completed by the attending Doctor)

10. a) Is specialist treatment being given? Yes No
10. b) If Yes, provide name and address of specialist
11. a) Is future medical treatment foreseen? Yes No
11. b) If Yes, what will the probable nature of such treatment be and in respect of which injuries?
11. c) Exptected date thereof:
11. d) Expected duration thereof:
11. e) Is it foreseen from the above medical treatment that the patient will recuperate fully from his/her injuries?
12. Is hospitalisation foreseen in connection with the future treatment referred to in 11 a)? Yes No
If Yes, state: a) Expected date of such hospitalisation: b) Expected duration thereof:

Doctor's signature:
Date:
Doctor's name:
Tel no.:
Qualifications:
Address: