



Allied Insurance Company

of the Maldives Pvt Ltd

#04-06 S.T.O. Trade Centre, Orchid Magu, Male', Republic of Maldives. Tel: (960) 32 46 12, Fax: (960) 32 50 35
email: info@alliedmaldives.com website: http://www.alliedmaldives.com

PERSONAL ACCIDENT CLAIM FORM

It is very important that a complete answer to be given to every question. If insufficient space is provided for your answer please continue on a separate sheet.

CLAIM NO.	ACCOUNT NO.	POLICY NUMBER	RENEWAL DATE	NAME OF AGENT
			/ /	

Insured or Policyholder

Full Name _____

Postal Address _____

_____ Tel No. _____

Injured Person

Full Name _____ Age _____

Private Address _____

_____ Tel No. _____

Business address _____

_____ Tel No. _____

Employment / Occupation _____

Accident

Date _____ Time _____ am / pm *

Place _____

State fully what happened _____

What was the Injured Person doing at the time? _____

*DELETE AS REQUIRED

Injury or Illness

Nature of injury or illness _____

Has he previously suffered from an injury to the same part or a similar illness? YES / NO *

If YES, give details _____

How long has he been disabled from engaging in or attending to his usual employment or occupation as a result of the injury or illness?

(a) TOTALLY : From _____ To _____

(b) PARTIALLY : From _____ To _____

Name and address of the Doctor attending the injured person _____

Is he the injured person's usual doctor? YES / NO *

Other Insurance Compensation

Is the injured person claiming under any other insurance or receiving compensation from any other source? YES / NO *

If YES, give details _____

I / We declare that these particulars are true to the best of my / our knowledge and belief

Injured person's signature: _____ I/D No. _____ Date _____

Insured's Signature _____ I/D No. _____ Date _____

*DELETE AS REQUIRED

Notes:

1. It is important that the Medical Report opposite should be completed by a fully qualified and registered medical practitioner.
2. If you are claiming for reimbursement of medical or other expenses full details and documentary evidence must be provided.
3. If compensation is related to salaries or wages a signed statement should be attached, giving the total remuneration paid by the Insured or Policyholder to the injured person during the twelve months prior to the accident of illness

1. Name of Patient	
2. From what injuries of illness is the Patient now suffering?	
3. When were you first consulted for these injuries or illness?	
4. How long has the Patient been disabled from engaging in or attending to his usual employment or occupation as a result of these injuries or illnesses?	<p>Totally from _____ to _____</p> <p>Partially from _____ to _____</p>
5. How much longer do you consider such disablement will continue?	<p>Totally from _____ to _____</p> <p>Partially from _____ to _____</p>
<p>6. Has the Patient any other disease or physical defect?</p> <p>If YES, (a) What is the nature?.....</p> <p>(b) To what extent may recover be effected thereby?</p>	<p>YES / NO *</p> <p>(a)</p> <p>(b)</p>
<p>Signature: _____ Qualifications: _____</p> <p>Address: _____ Date: _____</p>	