prabhu INSURANCE®
protecting your future.

Prabhu Insurance Limited

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PERSONAL ACCIDENT CLAIM FORM

Policy No..... Claim No:.....

This form is issued without admission of liability and must be completed and returned within seven day Receipt No . claim can be admitted unless the MEDICAL CERTIFICATION OVERLEAF is furnished .

INSURED

1. Name in full:.....
   Address:.....
   .....Tel No:.....

EMPLOYEE

2. Name:.....Age:.....
   Home Address:.....
   .....
   Occupation:..... Monthly Earning Rs.....
   This average weekly amount paid by the Insured to the Employee during the twelve months preceding the accident or during any shorter period of employment.

(a)	Date and Time of Accident :	.....
(b)	where did it occur ?	.....
(c)	Details of the cause	.....
(d)	Injuries sustained	.....

4. Name and address of any witness:

5.	(a)	Name and address of doctor who attended employee.	
	(b)	Name and address of employee's ordinary medical attendant.	
6.	(a)	Period during which employee has been totally disabled for work as the sole and direct result of the accident .	.....
	(b)	Is employee still disabled? If so, when does he expect to return to work.	.....

I/ WE HEREBY DECLARE that the above named employee received the above described injuries and that to the best of my/our knowledge the foregoing particulars are in every respect true.

Date: Signature:

MEDICAL CERTIFICATE TO THE COMPLETED BY EMPLOYEE'S DOCTOR

I CERTIFY that .....

was injured on .....

His injuries are .....

.....

If his injuries are complicated by and other conditions, give details.....

.....

He is totally disabled and will be so disabled until.....

.....

Signature and
Qualification

date :.....

Total Disablement occurs when Employee is wholly prevented from attending to his business or occupation.