



**PERSONAL ACCIDENT CLAIM FORM**

CLAIM NO. \_\_\_\_\_

Please print clearly in BLOCK LETTERS throughout. Answer all questions, selecting the necessary check box as appropriate and indicating Not Applicable if necessary. Date format is DD/MM/YY.

Branch or Agent \_\_\_\_\_ VAT No. \_\_\_\_\_

Policy No. \_\_\_\_\_ Account No. \_\_\_\_\_

This Form is issued without admission of Liability and must be completed and returned within seven days after its receipt. No Claim can be admitted unless the MEDICAL CERTIFICATE OVERLEAF is furnished at the expense of the Claimant.

**SECTION 1** DETAILS OF INSURED

Name in Full \_\_\_\_\_ Tel No. \_\_\_\_\_

Email \_\_\_\_\_ Cell No. \_\_\_\_\_

Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs.

Residence Address \_\_\_\_\_

Business Address \_\_\_\_\_

Present address or occupation \_\_\_\_\_

(If more than one, state all) \_\_\_\_\_

Address where breakage occurred \_\_\_\_\_

Noting the definition below, please select which of the following is applicable to you:

Politically Exposed Person (PEP)       Related to a Politically Exposed Person (PEP)       Not Applicable

A **Politically Exposed Person** (PEP) is one who has been entrusted with prominent public functions, for example a head of state or of government, senior politicians, senior government, judicial or military officials, senior executives of state-owned corporations, important political party officials. This category also includes immediate family members close personal and professional associates.

**SECTION 2** DETAILS OF CLAIM

<p>1. (a) When did accident occur? State date and time</p> <p>(b) Where did it occur?</p> <p>(c) Give full particulars of the cause and the injuries sustained</p>	
<p>2. Provide Name, tel. nos. and address of each witness</p>	
<p>3. (a) Give name and address of Doctor who attended you</p> <p>(b) Name and address of your ordinary General Practitioner</p>	
<p>4. (a) State where and when a Medical or other Officer of the Company can visit you, if necessary</p>	

<p>5. (a) State this period during which you have been totally disabled from attending to your business as the sole and direct result of the accident</p> <p>(b) Are you disabled? If No, from what date were you able to attend to some part of your business?</p>	<p>From: _____</p> <p>To _____</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>From: _____</p>
<p>6. (a) Have you previously received compensation under an Accident and/or Sickness Policy? If Yes, please give particulars</p>	<p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p>
<p>8. (a) Are you insured elsewhere?</p> <p>(b) If Yes, give the name of each Company or Insurer, and amount you are entitled to claim</p>	<p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p>

**SECTION 3   DECLARATION**

I/We hereby declare that the foregoing particulars provided by me/us are true and correct to the best of my/our knowledge and belief. I am/we are aware that the failure by me/us to provide information that is true and correct to the best of my/our knowledge and belief, or the withholding of information relevant to this claim may result in CG United Insurance Ltd. denying or voiding this claim, or in criminal prosecution and/or civil proceedings being brought against me/us in accordance with relevant Laws.

**Data Protection Declaration:**

By signing this form, I confirm/understand that:

- In order to administer the policy and plan CG United Insurance Ltd. may process any and all of the personal data provided.
- I consent to CG United Insurance Ltd. processing my personal data, in accordance with CG United Insurance Ltd.'s Privacy Policy (<https://international.cgcoralisle.com/privacy-policy/>). For additional information on your rights and how to exercise them, please access or request this Policy.
- I confirm that any personal data I provide to CG United Insurance Ltd. in respect of any third party, is done with that third party's consent and knowledge of CG United Insurance Ltd. processing of their personal data.
- I have the right for my personal data to be processed in accordance with the rights of Data Subjects under the relevant jurisdictional privacy legislation.
- I understand that this form shall be incorporated into and shall constitute a part of the policy contract between me/us and the Company.

Signature of Insured \_\_\_\_\_ Date \_\_\_\_\_