

# Personal Accident



## Claim Form

*How can we help you?* We give claims our greatest possible care and try to deal with them as quickly as possible - because we know that this is important to you when you submit a claim.

Please help us to help you by:

- making sure that the information you give is as clear and complete as possible
- remembering to sign and date this form

**Important Note:** You must enclose estimates/valuations/receipts with this claim form.

Ref No

### FOR ALL CLAIMS PLEASE COMPLETE THIS SECTION

#### 1. Insured

Name	<input type="text"/>	Mr/Mrs/Miss/Ms	Policy No.	<input type="text"/>
Address	<input type="text"/>			
Occupation	<input type="text"/>			
Telephone Number	Home <input type="text"/>	Business	<input type="text"/>	
Please provide details of	Age <input type="text"/>	Height <input type="text"/>	Weight	<input type="text"/>
At time of accident, were you gainfully employed ?	Yes <input type="checkbox"/>	No	<input type="checkbox"/>	

#### 2. General

Name and Address of Doctor in attendance	<input type="text"/>			
<b>Note: Please ensure that Medical Certificate overleaf is completed by this Doctor</b>				
Is he/she your usual Medical Attendant ?	Yes <input type="checkbox"/>	No	<input type="checkbox"/>	
When can you be seen ?	<input type="text"/>			
How long have you been				
a) wholly unable to attend to any portion of your profession or occupation ?	from	<input type="text"/>	to	<input type="text"/>
b) able to attend only partly to your profession or occupation ?	from	<input type="text"/>	to	<input type="text"/>
Names and Addresses of any other Insurer or Society or Club from which you are entitled to benefit in respect of the same accident/sickness	<input type="text"/>			

### 3. Details of Accident

Place

Date     Time  am/pm

Please give full details of accident, indicating what you were doing at the time

What injuries have you sustained ?

Have you previously suffered from similar injuries ? Yes  No

If so, please give details

Names and Addresses of witnesses

When did incapacity start ?

### Declaration

I/we hereby declare that the statements on this form and the information provided in addition are true and complete, to the best of my/our knowledge and belief.

Signature(s)   Date

### 4. Medical Certificate

This is to certify that • Mr/Mrs/Miss/Ms

is suffering from

and \* will/will probably be unfit to resume work until (\* Delete as necessary)     Disablement from attending to usual business or occupation commenced on

*(Total disablement occurs when the Insured is wholly prevented from attending to his/her business or occupation whereas partial disablement shall mean disablement from a substantial part of the Insured person's usual occupation)*

If a date of return to work can be given, please complete the following

Temporary total disablement from     to

Temporary partial disablement from     to

Is surgical intervention necessary or likely to be so ? Yes  No

Is Insured Person confined to bed or house ? Yes  No

On the basis of your existing knowledge and without undertaking any further examination, is it your opinion that the disablement indicated above is solely attributable to the specified injury sustained ? If not, please state below any contributing factors and the extent to which disablement is or has been thereby affected

Signature and Qualification   Date

**NOTE FOR DOCTORS Any fee for this certificate is to be paid by the patient.**

**Notes for Policyholders** Any fee for the medical certificate is payable by the Insured. Further medical certificates are required at fortnightly intervals during periods of disablement. Interim payments of benefits are normally made on request subject to satisfactory medical evidence. Insured may be required to submit to medical examination on behalf of and at the expense of Royal & SunAlliance in connection with any claim.

Please return the completed form with the relevant evidence of the amount claimed

The Claims Department, Royal & SunAlliance. 13/17 Dawson Street Dublin 2.

Telephone: (01) 6771851. Facsimile: (01) 6717626