INSURANCE COMPANY (JAMAICA) LIMITED

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PERSONAL ACCIDENT CLAIM

Date of Accident		Time of Accident		Policy No.	Renewal Date
Place Accident happened					

INSURED	Name							**FOR OFFICE USE**	
	Address								
	Type of Business								
	Business Address								
	Tel Nos.		(h)		(w)		(c)		
INJURED PARTY	Name		Address						
			Occupation						
	Tel Nos.		(h)		(w)		(c)		
	Age		Height		Weight				

ACCIDENT	State how the accident was caused and what you were doing at the time						
	Name of witness		Address				
		Tel Nos.		(h)		(w)	(c)
INJURIES	What injuries have you sustained? (If to an eye, hand or arm, foot or leg, please state whether it is the right or left)						
DISABILITY	How long have you been confined to your bed or house?		Are you still confined to your bed or house?	○ Yes	○ No		
	To what extent have you been able to attend to business or engage in any occupation since the accident?						
	Wholly disabled		Partially disabled		Present state of disability		
	For	days	For	days			
GENERAL	Name and Address of Doctor attending you						
	Is he/she your usual Medical Attendant?	○ Yes	○ No	If so, give particulars			

Date _____ Signature _____

MEDICAL CERTIFICATE *(to be completed by your Doctor)*

I CERTIFY THAT the above person is suffering from _____

and he/she has been totally unable to work from the _____ day of _____ 20_____ and disablement is the direct and evident consequence of an accident to him/her, particulars of which are given above.

Date _____ Qualification _____ Signature _____

The fee (*if any*) for this Certificate to be paid by the claimant

PRINT

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