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PERSONAL ACCIDENT CLAIM FORM

The prompt completion and return of this form, including the medical certificate will assist in the handling of the claim

Name of Insured _____ Present Age _____ Policy No. _____

Address _____ Tel. No. _____

Occupation (if more than one, state each) _____

Name and Address of Doctor in attendance in respect of the injury _____

Name and address of your usual Doctor _____

From what date were you totally disabled from attending to your usual business or occupation? _____

From what date were you partially disabled from attending to your usual business or occupation? _____

If still disabled, when do you expect to resume your usual business or occupation? _____

Is your disablement due solely to the injury [? _____

If not, please give details _____

Please give details of any benefit to which you may be entitled under any other insurance policy or club scheme, with the name and address of the insurers or club _____

Date of accident _____ Time _____ a.m/p.m.place _____

Description of accident _____

Names and address of witnesses _____

Nature of injury _____

Have you suffered a similar injury before? _____ If so, when? _____

I declare that the foregoing particulars are true and complete

Date _____ Signature of Insured _____

DATA PROTECTION NOTICE AND CONSENT

Lasaco Assurance Plc is data protection regulation compliant. All information submitted by you will be processed and managed in line with the Nigeria data protection regulation.

Sign

MEDICAL CERTIFICATE

**TO BE COMPLETED BY A QUALIFIED AND REGISTERED MEDICAL PRACTITIONER
AND SUPPLIED AT THE EXPENSE OF THE INSURED**

Name of Insured _____

Nature of injury _____

Date of first attendance for this injury _____

If there is any history of a similar previous injury, please give details _____

Do you know of anything which directly or indirectly might have contributed to, or is in any way likely to retard recovery from the present injury? _____

Period of total disability from attending to the insured's usual business or occupation From _____ to _____
inclusive

Period of partial disability from attending to the insured's usual business or occupation From _____ to _____
inclusive

If still disabled, please state the probable further period of

(a) Total disability from attending to the insured's usual business or occupation _____ From _____ to _____
inclusive

(b) Partial disability from attending to the insured's usual business or occupation _____ From _____ to _____
inclusive

General remarks _____

Date _____ Signature _____

Qualification _____

Address _____