MUI Continental Insurance Berhad (29123-D)

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A member of The MUI Group
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OFFICE MEMORANDA

Claim No: .....
Agency: .....
A/c Code No: .....

PERSONAL ACCIDENT CLAIM FORM

PLEASE GIVE A DEFINITE ANSWER TO EACH QUESTION: TICKS OR DASHES ARE NOT SUFFICIENT

This form is issued without admission of liability, and must be completed and returned within fourteen days after the occurrence of the accident. No claim can be admitted unless the medical certificate overleaf is furnished at the expense of the Claimant.

1. Name in Full: ..... Policy No. .....

   House Address: ..... Tel: .....

   Name of Employer: ..... Occupation: ..... Age .....

2. Date and Time of Accident	
3. Place of Accident	
4. State how the accident occurred and what you were doing at the time (It is necessary that the fullest particulars be given. If space is insufficient, please attach separate sheet a and continue).	
5. State as precisely as you can the injuries you have sustained	
6. Give names and address of persons who witnessed the accident.	
7. (a) Give name and address of the doctor who attended you after the accident	a)
(b) Is he your usual medical attendant? It not, state reason why he was consulted.	b)
8. (a) Number of days you are unable to attend work / duty.	a) .....days
(b) Number of days you are able to attend to a portion of your usual business or occupation.	b) .....days

Please attach medical leave chits and a letter from your employer certifying the number of days you are unable to attend work / duty.

9. State whether in respect of the accident you are entitled to receive compensation from any other source. If so, from what source and to what extent.	
10. Have you ever made a claim for compensation in respect of accidental injury from any insurer? If so, state name of company, amount and date received.	

I HEREBY DECLARE that I have received the injuries above described, and warrant the truth of the foregoing particulars in every respect, and agree that if I have made, or I shall make, any false or untrue statement, suppression or concealment, my right to compensation shall be absolutely forfeited. I further authorise the release of further medical information by the doctor in attendance should the Company require it.

Date ..... Signature of Claimant/Company's Chop .....

PLEASE HAVE YOUR MEDICAL ATTENDANT COMPLETE THE MEDICAL CERTIFICATE OVERLEAF.

MEDICAL CERTIFICATE

PLEASE GIVE A DEFINITE ANSWER TO EACH QUESTION: TICKS ON DASHES ARE NOT SUFFICIENT

Note: This certificate is to be completed in full by a duly qualified and registered medical practitioner.

1. (a) Name of Claimant: (b) Occupation: (c) Identity Card No of Claimant: (Attach Photocopy)	....
2. When did you first attend the claimant in consequence of the injuries sustained?	
3. Are you still in attendance?	
4. Are you his usual medical attendant? If so, how long have you known him, and for what other ailment have you treated him?	
5. full particulars of injuries caused by the accident (If a limb or an eye state whether it is the left or right)	
6. (a) Are his symptoms (i) due exclusively to the accident, or (ii) traceable to disease, infirmity or any other casue? (b) Has he ever suffered from a fit of any kind? (c) Is there anything in his medical history which may have contributed, directly or indirectly, to the accident, or which may be likely to retard his recovery? (d) Have you any reason to suppose that he was under the influence of intoxicants at the time of the accident?	(a) i) ..... ii) ..... (b) ..... (c) ..... (d) .....
7. In your professional opinion taking into account the claimant's occupation, to what extent the above accidental injuries have necessarily disabled the claimant. (see note below) Please attach Medical leave chits certifying the period claimant unable to work (Totally Disabled).	(i) Totally disabled: (Number of days claimant is unable to attend to his work/duty) ..... days (ii) Partially disabled: (Number of days claimant attends part of his work//duty) ..... days
8. Is there now any disability? If not, please give date of recovery.	
9. (a) If the Claimant is now, in any way, attending to Business, on what day he first commenced doing so after the accident (b) If not, whether you consider Claimant fit to supervise or direct his Business or Occupation personally.	(a) ..... (b) .....
10. Any further remarks	

Note: TOTAL DISABLEMENT arises when the Claimant is rendered completely incapable of attending to any part of his ordinary profession, business or vocation.

PARTIAL DISABLEMENT arises when the Claimant is capable of attending to some portion of his ordinary profession, business, or vocation including supervision.

I certify that I have satisfied myself by personal examination that the claimant has sustained and accident causing injuries as above described, and to the best of my belief the foregoing statements are correct and should the Company require further medical information in connection with the above, I would release the said information upon the sanction of the claimant.

Signature .....

Qualification .....

Date ..... 20 .....

Address .....

Telephone .....
(must be completed)