SIC INSURANCE COMPANY LIMITED

P.O. Box 2363, Accra Ghana
HEAD OFFICE: NYEMITEI HOUSE 28/29 Ring Road East. Tel (030) 2-280600-9 Fax (030) 2-780615
Ring Road West: (030) 2-228926/ 228922/228962/228987/ 230041-2, Fax (030) 228970/ 224218
E-mail:sicinfo@sic-gh.com Website: www.sic-gh.com

GROUP PERSONAL ACCIDENT CLAIM FORM

The company does not admit liability by the issue of this form

1. Policy Number...
2. Name of Insured...
3. Address of Insured...
4. Name of Injured /Deceased...
5. Phone No...
6. Occupation/Position of Injured...
7. Date of Birth.. Age...
8. Place & Date of Accident...
9. Annual Salary/ Fixed Sum Insured...
10. E-mail Address (If any)...

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11. How did the accident happen and what were you doing at the time?...

    ....
12. Please give the Name(s) & address of any witness(es) to the accident...
13. What injuries did you sustain?...
14. Name of Hospital/Clinic attended...
15. Is the Doctor who attended to you your usual Doctor?...
16. How long have you been temporarily disabled & have not been able to go to work?

    From.. To...
17. Have you required/undergone any medical or surgical treatment during the past five (5) years?...

    If so, please give details...
18. Are you claiming under any other policy for this accident?...

    If so, please give details...

DECLARATION OF VICTIM

I declare that the above answers are true and complete

Signature.. Date...

CERTIFICATE OF INSURED

We certify that the above injured/deceased is/was an Employee of the Company and details declared therein are true

Signature... Stamp............................ Date...

MEDICAL CERTIFICATE

This certificate is to be completed by a duly Qualified and Registered Medical Practitioner at the Insured's expense

1. Name of Patient..

2. What are his/her injuries?...

   ....

   ....

3. When did you first attend to him/her?...

4. (a) Has the Patient any disease, disability or physical defect apart from, the effects of this accident?.........................

   If so, please give details...

   (b) If he/ she has, to what extent

   (i) Was the accident attributable to it?..

   (ii) Is recovery retarded by it?..

5. State how long the patient has been temporarily disabled and for which period you gave him/her permission (Excuse duty) to stay out of work: From.. To...

6. Date Patient was declared fit for work...

Name of Medical Officer...

Qualification..

Address...

Signature.. Date..