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

PERSONAL ACCIDENT CLAIM FORM

Name of Insured..... Policy number.....

Address of Insured.....

Business or Occupation.....Age.....Height.....Weight.....

Date of accident.....Time.....Place.....

Occupation/Position of Injured.....

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

   .....

   .....

   .....

2. Please give the names and addresses of any witnesses of the accident.....
3. What injuries did you sustain.....

   .....

4. (a) What is the name and address of the doctor attending to you?.....

   (b) Is he/she your usual doctor?.....

5. (a) How long have you been temporarily totally disabled and have not been able to go to work?

   From..... To.....

   .....

6. Have you required medical or surgical treatment during the past five years? If so, please give particulars

   .....

7. (a) Are you claiming under any other policy for this accident?.....

   (b) If so, please give details.....

   .....

DECLARATION OF VICTIM
I declare that the above answers are true and complete

Insured's Signature..... Date.....

P.T.O

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.....