Qatar Insurance Company

PERSONAL ACCIDENT CLAIM FORM

(THE ISSUANCE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY BY THE INSURER)

Policy No.:	Claim No.:

THE POLICY HOLDER **(Name, Address and Phone)**	

THE INJURED

1. Name:		**2.** Male/Female:
3. Nationality:	**4.** Age and Date of Birth:	
5. Occupation:	**6.** Monthly Salary/Daily wage:	**7.** Policy List No.:

THE ACCIDENT

8. Date:	**9.** Place:	**10.** Time: am/ pm

11. Circumstances and description of the accident:

12. Nature and extent of injury:

13. Whether the Police were informed of the accident? Yes/ No
(If so, please enclose Police Report.)

14. Name/(s) and address/(es) of other person/(s), if any, involved in the accident:

15. Name/(s) and address/(es) of witness/(es):

16. Was the injured person free from physical defect or infirmity at the time of the accident? If not give details.

17. Has the injured been received any medical attention? If so, give the name and address of the hospital and the doctor by whom treatment was given. **(Attach medical report(s) stating details as per the attached format.)**

18. Has the injured person unable to attend to whole/part of his normal business? Yes/No **19.** Is a claim being made under any other Personal Accident Insurance? If so, please give details.	Totally disabled From…….…….To……………… Partially disabled From…………To……………... Fully fit for duty from………………………………

Following documents are attached hereto: — please tick (√) the appropriate

( ) Medical Reports, Unfitness / Fitness Certificate (s) and Medical Expense Bills.

( ) Medical Board's Assessment Report on Permanent Disability, if any.

( ) Police Report.

( ) Post-mortem Report and Death Certificate, if applicable, with a copy if ID/Visa/Passport.

( ) Beneficiary/Succession Certificate.

( ) A copy of the List of Members included in the Policy.

( ) Others.

( )

Date: **Signature and stamp of the Insured/Injured**

<u>FOR OFFICE USE ONLY</u>

Computation of compensation payable:—

P.O.Box 666, Doha, Qatar Telephone: (+974) 4962 222 Fax: (+974) 4831569

MEDICAL CERTIFICATE (ATTENDING DOCTORS REPORT)

1. a)Name and Age of Injured Person b) Address of the Injured Person	
2. Describe nature and extent of Injuries.	
3. Cause of the accident as far as you know it. (a) When did you first attend on the Injured person following the accident? (b) Are you still attending on him? (c)Are you his usual Medical Attendant?	
4. If you have treated him for any previous illness or injury, please give details.	
5. Are his injuries, (a) solely due to the accident, or (b) Traceable to any disease, infirmity, previous injuries, or any other cause?	Yes/No.
6. Is the injured person suffering from any disease or injury (apart from this injury) which directly or indirectly	
(a) may have contributed to the accident, or	
(b) is likely to retard his recovery from the injuries, or	
(c) is likely to aggravate his condition?	
7. Was he to your knowledge under the influence of intoxicants or drugs at the time of accident?	
8. (a)Do you recommend that the injured person to be confined to bed/house at the direct and sole consequence of the injuries sustained? Totally disabled from……..…………………………...to……………………. Partially disabled from………………………….….to……………................ Date of resumption of his normal duties fully from………………………	
9.Any other remarks you wish to make	

I, hereby certify that the injuries sustained by the Person mentioned above are in accordance with the nature of the accident as described to me and that I treated him for the said injuries.

Name

and address

Doctors Stamp and Signature with Registration No and Qualifications

Date:-

(Note:-The fee, if any for this Report will be borne by the injured person.)