

P.O.Box. 2907, Ruwi, Postal Code:112, Sultanate of Oman

## The issue to this form is not to be taken as an admission of Liability

## Personal Accident Insurance Claim Form (Particulars) of Accident)

			Policy No
			Period
			Claim No.
		TO BE COMPLE	TED BY THE INSURED
1.	(a)	Name of the Insured [in full]	
	(b)	Name of the injured Person	
	(c)	Address in full	
	(d)	Profession or occupation	
	(e)		
2.	(a)	Date of the accident?	
	(b)	Time of accident?	
	(c)	Where it happened?	
	(d)	Name and address of witness	
3	How	did the accident occur?	
4.	Nature of injury received		
	(If to	limb or eye state whether right or left)	
5.	(a)	Nature of disablement	
	(b) Extent of disablement		
	Confined to bed		[ from To]
		Confined to house	[ from To]
	(c)	Present state of incapacity	
i i			

Name ar	nd address	of surg	eon ir	n attendance						
(a)										
ot attempte ave not ab nade, or in ent or any a compensa Peace of the	ed to conce stained fro any furth suppression tion forfeith he truth o	eal from om any er decla on, cond ed and	the Cusual aration ealm am w	Company anyth occupation lo not the Comparent or untrue a rilling, if require	hing wi enger tl ny may averme ed to r	hich it ou han abso require ent whate nake a S	ght to build to build to be seen	e made acquecessary armake any face Policy sha	uainted and add I agree that alse or fraud II be void and before a Ju	also at if I ulent d my stice
				Signati	ure of	the Insur	ed			
Signature				_ Date :						
s										
hereby	certify	that	I 	was pres On the _ in the mai	sent nner s	when tated by	the	Accident er leaf, that	occurred day it was cause	d by
			_ *****	ii was / was	יווטנוו	is williui	act and	triat no w		IIGCI
					5 1101 11	is willium	act and	that no w		ilaci
					5 1101 11					
1	(a) Whe of th (a)  eby declared attempted ave not about attempted ave not about about a compensation with the second attempted attempted ave not about a compensation with the second attempted atte	(a) Where and who of the Compane (a)  eby declare that the ot attempted to conceave not abstained from the angle of the truth of the compensation forfeit Peace of the truth o	(a) Where and when can of the Company visit you (a)  eby declare that the foregoing of attempted to conceal from any eade, or in any further declarent or any suppression, concompensation forfeited and Peace of the truth of the writion with this claim.  CERTIFIED TO BE FILLED  hereby certify that	(a) Where and when can a Moof the Company visit you, if  (a)  eby declare that the foregoing state attempted to conceal from the Coave not abstained from any usual rade, or in any further declaration compensation forfeited and am we reace of the truth of the whole of the truth	eby declare that the foregoing statements are most attempted to conceal from the Company anythave not abstained from any usual occupation logade, or in any further declaration the Comparent or any suppression, concealment or untrue a compensation forfeited and am willing, if required access of the truth of the whole of the foregoin tion with this claim.  Signature Date:  CERTIFIED TO BE FILLED UP AND SIGNED  hereby certify that I was pression to the main control of the mai	(a) Where and when can a Medical Officer of the Company visit you, if necessary?  (a)  eby declare that the foregoing statements are made by the attempted to conceal from the Company anything where the any suppression, concealment or untrue averned compensation forfeited and am willing, if required to recease of the truth of the whole of the foregoing statement or with this claim.  Signature of the certification of the certification with this claim.  CERTIFIED TO BE FILLED UP AND SIGNED BY AND The certification with the manner signal of the certification of the certification of the certification of the certification with the certification of the certif	(a) Where and when can a Medical Officer of the Company visit you, if necessary?  (a)  (a)  (b)  (b)  (b)  (c)  (e)  (b)  (e)  (b)  (e)  (e)  (e)  (e	(a) Where and when can a Medical Officer of the Company visit you, if necessary?  (a)  eby declare that the foregoing statements are made by myself and are at attempted to conceal from the Company anything which it ought to be ave not abstained from any usual occupation longer than absolutely neade, or in any further declaration the Company may require, shall nent or any suppression, concealment or untrue averment whatever, the compensation forfeited and am willing, if required to make a Statutory Peace of the truth of the whole of the foregoing statement or any of the tion with this claim.  Signature of the Insured	(a) Where and when can a Medical Officer of the Company visit you, if necessary?  (a)  eby declare that the foregoing statements are made by myself and are true in all of attempted to conceal from the Company anything which it ought to be made acquave not abstained from any usual occupation longer than absolutely necessary ande, or in any further declaration the Company may require, shall make any fent or any suppression, concealment or untrue averment whatever, the Policy shall compensation forfeited and am willing, if required to make a Statutory Declaration Peace of the truth of the whole of the foregoing statement or any other statement ion with this claim.  Signature of the Insured  Date:  CERTIFIED TO BE FILLED UP AND SIGNED BY AN EYE WITNESS TO THE ACCUMENT ON the  On the  20 in the manner stated by him over leaf, that	(a) Where and when can a Medical Officer of the Company visit you, if necessary?  (a)  beby declare that the foregoing statements are made by myself and are true in all respect and to attempted to conceal from the Company anything which it ought to be made acquainted and are not abstained from any usual occupation longer than absolutely necessary and I agree that ade, or in any further declaration the Company may require, shall make any false or fraud accompensation forfeited and am willing, if required to make a Statutory Declaration before a Jupicace of the truth of the whole of the foregoing statement or any other statement I may make the made and the statement I may make the made and the statement I may make

Occupation \_\_\_\_\_

\* Strike out which is not applicable

## **MEDICAL CERTIFICATE**

Claims must be Supported by medical Evidence furnished by the Insured and at his

expe	ense.							
1.	(a)	Name of Claimant	(b) Sex	(c) Age				
2.	(b)	Nature and cause of accident						
	(b)	If to eye or limb, state left or ri	ight					
	(c)							
3.	Date on which you first attended Claimant for this injury							
4.		Has Claimant been totally prevented from attending to any portion of his business? If so how long?						
1.	Fron	Is Claimant suffering from any disease or illness apart From his injury and is there any illness by circumstances Which may tend to retard recovery? If so, give particulars?						
2.	Pres	ent Condition						
7.		long from the happening of the I disablement will last?	Accident do you consider					
	• •	sonally examined the above nar and that the injured person is ne	-					
Sigr	nature_							
Qua	lificatio	n						
Add	ress		_					
Date	э							

## **REMARKS FOR EXTRA DETAILS**