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PERSONAL ACCIDENT CLAIM FORM

1. N	Name in full		
	Age next birthday Present profession or occupation		
3. I	Present address		
	 (a) When and where did the accident occur? (b) How did it happen? (Full description to be given) (c) Name and addresses of any witnesses of the accident. (d) Name and address of Doctor who attended you immediately after the accident. (e) Name and address of Doctor now attending you. 	Date	
	(a) Did the incapacity commence from the date of the accident?(b) If not, when did it commence?		
,	Are you entitled to compensation from any other company or any club in respect of the injury for which you are claiming? If so, full particulars to be given.		
	When can a medical or other officer of the company visit you if necessary.		
	sured's Medical Attendant, any fee for th	ted by a report on the reverse side of this form from the e report being payable by the insured.	
1.	The undersigned, hereby declare that I am the pers made without reservation and I hereby claim to be	on referred to in the above statements, which are true every respect an paid.	
(a)	Compensation at the rate of	per week, as from	
(b)	to accept in settlement of any claim.	which I agree	
De	elete (b) if total claim cannot now be made, or (a)	if total claim can be made.	
		Signature	

CL/PA/047

P.T.O.

MEDICAL REPORT

Name of Patient.		
Describe fully the cause and circumstances of the accident as stated to you?	n - were det de pp dêt ten jugaryewe 1918e	ETZT - MINET JEHN - WEIGE VERB - ON - GARDE ENAMIGIA - HORROUTS - AS A CO (MINU) Edis M
Are the appearances of the injuries consistent therewith and do you believe they were caused as stated?	CCIDEN ad return wi	PERSONAL A per codipieted by the Justiced and his Buctor a
Nature of injury-please give detailed particulars		Tan emak".
On what date did the Patient first consult you in connection with this accident?		(a) Age rest birthday (b) Pressor profession or occupation
5. Are you the Patient's usual Medical Attendant? If so, how long have you known him?		
6. Is the Patient suffering from any injury or disease irrespective of that stated above? If so, please state nature of the same and to what extent recovery may be affected thereby,	Calc	(a) When and whom did the accident occur? (b) How did it happen?
7. Is the Patient on your advice:-		(Fell description to be given)
(a) Confined to bed. (b) Confined to have? If so, state probable		From to
(b) Confined to house? If so, state probable duration of such confinement from this date.	(0)	
(c) Able to get out of doors?	(c)	From to
8. If the Patient is in your opinion unable to give any attention to his profession or occupation, please state: (a) Date of commencement of total disablement (b) Patient description for attitude.	(a)	ettending you. (a) 174d the incapacity conuncince from the date of the sociolent? (b) If not, when did it omnumence?
(b) Probable duration from this date.	(a)	
 9. If the Patient is in your opinion able to give partial attention to his profession or occupation, please state:- (a) Date of commencement of partial disablement (b) Probable duration from this date. 	(b) (b)	
10. If disability has terminated, please state date of termination.	et o ed les)	no asar sa tanu inaalo waA shagali ka ilad
11. General Remarks.	T739-155	phared's Medical Alfondarol, pur factor (1 The undersigned, brieby doctors that I am the para made without reservation and I hereby claim to be de Compensation of the rate of
I certify that to the best of my be		going statements are correct

Signature.....

Address