প্রাইম ইন্স্যুরেন্স কোম্পানী লিমিটেড
Prime Insurance Company Limited
Head Office : 63, Dilkusha Commercial Area, Dhaka-1000,Bangladesh
Phone : 9562512 Fax : 880-2-9566923 E-mail:prime@ncll.com, G.P.O. Box. 2005

PERSONAL ACCIDENT CLAIM FORM

This form should be completed and returned within seven days of its receipt by the Insured.

PARTICULARS OF CLAIM

Name of Insured in full _____

Private Address _____

Business Address _____

Profession or Occupation _____ Present age _____ years.

Policy No. _____ Date of payment of last premium _____

1. State when and where the Accident took place — Date _____
2. State how it happened and what you were doing at the time. (It is necessary that the fullest details be given) — Time _____ am/pm; Place _____
3. State (a) What injuries you have sustained. (b) Whether you have ever had an injury to the same part before
4. Are you insured elsewher against Accidents ? If so, given particulars _____
5. Give the Names and address of any Witnesses of the Accident.
6. Give the name and address of the Medical Man who attended you on your meeting with the accident. Is he your usual Medical Attendant ? Has he, or any other Medical Man, attended you during the last five years for any illness or injury ? If so, give particulars.
7. Have you, as the direct result of the Aceident, been totally incapacitated from attending to business of any kind ? If so, state for how long. — From _____ To _____
8. Are you still totally incapable of attending to business of any kind. — From _____ To _____
9. State if (a) Confined to bed — From _____ To _____
   (b) Confined to house
   (c) Able to get out of doors
10. If now able to attend to any portion whatever of your business or occupation, state when you commenced to do so.
11. Have you fully resumed your usual business or occupation ? If so, since when.
12. When & where can you be visited by our Medical or other Officer ? Name nearest Railways Station & distance therefrom.
13. If you are prepared to agree to an immediate settlement please state the amount you are willing to accept.

I HEREBY WARRANT the truth of the foregoing statements.

Dated _____ 19 Signature _____

No Claim can be entertained without the certificate of a duly qualified and registered medical practitioner.

FORM-B

MEDICAL CERTIFICATE

(To be completed and signed by attending physician)

01. Name of claimant ----------

02. So far as you are aware, how did the injury arise? ----------

03. When did he first Consult you in connection with the accident ----------

04. Are you still in attendance? ----------

05. Are you the usual Medical attendant? If so, how long have you known to him? ----------

06. Please state fully the nature of the injuries sustained (If it is a limp or eye injured stated whether right or left) ----------

07. Are the symptoms from which he suffers due to the accident alone? ----------

08. Is the Claimant suffering from any disease in addition to the present injuries or has he any physical defect? ----------

09. State if the claimant by your advice is :

    a) Confined to bed ----------

    b) Confined to house ----------

    c) Able to get out of doors ----------

10. If the claimant is in your opinion unable to give any attention ----------
    to his profession or occupation, as described on the front page, please state ----------
    Date of commencement of total disablement probable future duration. ----------

11. In the event of the claimant being able to give partial attention to such profession or occupation please state ----------

    Date of commencement of partial disablement probable future duration ----------

12. If recovered please state date of recovery ----------

13. General remarks ----------

I certify that to the best of my belief the foregoing statements are correct

Signature of attending physician ----------

Address

C

PERSONAL ACCIDENT CLAIM FORM

(To be completed and signed by injured employee)

(Supplementary)

01. Name and Present Address ----------

02. Date of last medical attendance ----------

03. State how long you have been

a. Confined to house From ---------- to ----------

b. Able to get out of doors. From ---------- to ----------

4. How long have you been

a. Totally disabled From ---------- to ----------

b. Partially disabled From ---------- to ----------

5. If you are prepared to agree to an immediate settlement please state the amount you are willing to accept. ----------

I HEREBY WARRANT THE TRUTH TO THE FOREGOING STATEMENT

Signature ----------

Date ----------

D

MEDICAL CERTIFICATE

(To be completed and signed by attending physician)

01. Are you still attending the Claimant? ----------

02. What are his present symptoms? ----------

03. How long has be he been

a. Totally disabled From ---------- To ----------

b. Partially disabled From ---------- To----------

04. How much longer is it probable that the claimant's present state of disability will continue

5. GENERAL REMARKS ----------

I CERTIFY that to the best of my belief the foregoing statements are correct.

Signature ----------

Qualification ----------

Dated ----------

Address ----------