GENERAL ACCIDENT INSURANCE COMPANY JAMAICA LIMITED
58 HALF WAY TREE ROAD, KINGSTON 10

……….A………………………

PERSONAL ACCIDENT CLAIM

Date and Time of Accident ……………… ……………… am/pm Place Accident happened ………………	POLICY No.	RENEWAL DATE

		FOR OFFICE USE
INSURED	Name ……………… Address ……………… ……………… Occupation ……………… Tel. No. (Home) ……………… (Office) ……………… Age ……………… Height ……………… Weight ………………	
EMPLOYER	Employer's Name ……………… Business Address ……………… Business ………………	
ACCIDENT	State how the Accident was caused and what you were doing at the time	
INJURIES	What injuries have you sustained? (If to eye, hand or arm, foot or leg please state whether it us right or left)	
DISABILITY	How long have you been confined to your bed or house? ……… Are you still confined to your bed or house? ……… To what extent have you been able to attend to business or engage in any occupation since the accident? ……………… Describe the extent and duration of your disability Wholly Disabled For days Partially Disabled For days Present state of disability	
GENERAL	Name and Address of Doctor attending you ……………… Is he your usual Medical Attendant? ……… If not, who is? ……………… Are you claiming under any other insurance? ……… If so, give particulars ………………	

Date ……………… Signature ………………

MEDICAL CERTIFICATE (to be completed by your Doctor)

I CERTIFY THAT the above person is suffering from ………………

that he/she has been totally/partially unable to work from the ……… day of ……………… and I expect such

disablement to continue for ……… weeks ……… Days, from date shown below, and I am of the opinion that such

disablement is the direct and evident consequence of an accident to him/her , particulars of which are given above.

Date ……………… Signature ……………… Qualifications ………………

The fee (if any) for this Certificate t be paid by the claimant