PERSON ACCIDENT CLAIM FORM **CLAIM No.**_____

JAMAICA INTERNATIONAL INSURANCE COMPANY LIMITED

19 - 21 Knutsford Boulevard, New Kingston, P.O. Box 514, Kingston 5, Jamaica
Telephone No: (876) 926-3204 to 8, Fax No. (876) 968-1920
Website: www.jiiconline.com E-mail: jiic@gkco.com or info@jiiconline.com

Name_____ Age _____ Years

TRN _____ E-mail Address_____

Address Private _____ Tel. No. _____

Business _____ Tel. No. _____

Business_____

Policy No_____ Date of Payment of last premium_____

Date of Accident _____ Time_____ a.m./p.m. Place _____

1. How did the accident happen? What were you doing at the time?	
2. What injuries have you sustained?	
3. Has the same part been injured previously?	
4. How long have you been totally or partially disabled from engaging in or attending to your usual business as the result of the injuries?	
5. How long have you been confined to:- Bed? House?	 From_____ to_____ From_____ to_____
6. Name and address of Doctor who is attending you. Is he your usual Doctor	
7. Have you required medical or surgical treatment during the past five years? If so, give particulars.	
8. Names and addresses of any witnesses of the Accident	
9. Are you claiming under any other insurance? If so, give particulars.	

I WARRANT that the above statement and particulars are correct and complete.

Signature _____ Date _____

This Form should be completed and returned within seven days
It is necessary that the questions overleaf be answered by a registered medical practitioner.

MEDICAL CERTIFICATE

1. Name of Patient	

2. What injuries has the Patient sustained?	
3. When were you first consulted?	
4. How long has the patient been totally or partially disabled from engaging in or attending to usual business as the result solely of the injuries? How much longer do you consider such disablement will continue?	Totally from _____ to _____ Partially from _____ to _____ Totally from _____ to _____ Partially from _____ to _____
5. Has the Patient any disease or any defeat and if so of what nature? To what extent may recovery be affected thereby	

Signature _____ Qualifications _____

Address _____ Date _____