## PERSONAL ACCIDENT & INJURIES CLAIM FORM “A”

This form is forwarded on receipt of notice of an accident, and its issue to the policyholder is in no way an admission of a claim if the claim is from any cause already void. The Claim will be considered subject to the Terms and Conditions of the Supplementary Contract.

### (CLAIMANT'S STATEMENT)

1. Name (in full).______________________________

2. Profession, Business or Occupation (if more than one, state all). ______________________________

______________________________

3. If an Employee, give Name, Address and Business of Employer. ______________________________

______________________________

______________________________

4. Policyholder's Residence. ______________________________

5. Nearest Policy Station there too. ______________________________

6. Policyholder's Business Address. ______________________________

7. The Nearest Police Station is there too. ______________________________

8. Life Policy Number. ______________ Supplementary Contract Number. ______________

9. Policy-holder's Age ______________ Years ______________

10. Policy holder's bank account number & address ______________________________

______________________________

______________________________

11. Date of Payment of last premium paid ______________________________

### THE ACCIDENT

12. When did it occur? On the ______________ day of ______________ 20 At ______________ A.M./P.M.

13. Where did it occur? ______________________________

14. State, how the accident was caused, and what you were doing at that time ______________________________

______________________________

______________________________

(A full account must be given so that the Directors may understand clearly how the Accident occurred).

15. State as precisely as you can, what injuries you have sustained. ______________________________

______________________________

______________________________

______________________________

(If it is an eye, hand or arm, foot or leg please state whether it is Right or Left)

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**STATE LIFE**
**INSURANCE CORPORATION OF PAKISTAN**

2. Name and Address witness of the Accident

1) ___________________________________

2) ___________________________________

1. Name and address of the medical man's who attended to you for the injuries described. ___________________________________

2. Did you go to him, or did he come to you? ___________________________________

3. Is he your usual Medical Attendant? ___________________________________

Our Room? Your House?

Bedroom or House?

(If not confined to either, state so below) for ______ days ______ for ______ days for ______ days

| from ____________ | from ____________ | from ____________ |
| --- | --- | --- |
| to ____________ (both inclusive) | to ____________ (both inclusive) | to ____________ (both inclusive) |

5. If you are still confined to Bed, Room, House state which date ___________________________________

___________________________________

6. Present State of Disability

___________________________________

___________________________________

___________________________________

7. State to what extent you have been enabled, since the Accident, to give attention to any business, or to be engaged in any occupation

___________________________________

## ADDITIONAL INFORMATION

8. Have you ever been insured under any other policy, of State Life, Company, or Companies for Personal Accident and Injury Benefits? if so, give details ___________________________________

___________________________________

9. Have you ever made a claim or received any payment from State Life or any other Insurance Company? ___________________________________

10. If so, state the policy number of such claims ____________________ Total amount of Compensation.

Rs. ____________________ Year(s) of payment. ___________________________________

I hereby declare that I am the person referred to in the particulars contained herein and that I have received the injuries described before by violent, accidental, external, and visible means. I do further declare that I have always been uniformly sober and temperate in my habits that I was in no way under the influence of the intoxicating drug when the accident occurred, and that I have not abstained from business or work, either totally, or partially, longer than necessary in consequence of the said injuries, and that such injuries are the sole and direct cause of my disablement. I do hereby warrant the truth of the foregoing statements in every respect, and I agree that if I have made, or in any further declaration in respect of the said accident, shall make any false or fraudulent statement or any suppression, concealment, untrue, averment whatever the Policy shall be void as against the State Life and my right to compensation absolutely forfeited and I am willing, whenever required to make a solemn declaration before a Justice of the Peace or a Magistrate First Class of the truth of the foregoing statements and of such other particulars as may reasonably be required by the Directors I hereby claim to be paid the weekly sum assured by my Policy, as follows

STATE LIFE
INSURANCE CORPORATION OF PAKISTAN

During Total Disablement RS: ______________________ per Week

During Partial Disablement RS: ______________________ per Week

or, if State Life prefers, I agree to accept the total sum of Rs. ______________________

being ______________________ week's Total and ______________________ week

weeks Partial Disablement Allowances), in full satisfaction, liquidation, and discharge of all Claims upon the State Life in respect of all injuries whether now or hereafter to become manifest arising directly or indirectly from the before-mentioned accident; and I agree that this offer shall hold good for fourteen days from this date.

Signed at ______________ this ______________ day of ______________

______________________

**Signature of the Claimant**