FPG insurance

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MEMBER OF THE ZUELLIG GROUP

NOTIFICATION OF CLAIM
PERSONAL ACCIDENT

FORM A

Claim No. xxxxxxxxxxxxxxx
Policy No. xxxxxxxxxxxxxxx

POLICY HOLDER

Name (in full):	**Occupation** (describe fully):	**Age:**
Private Address (in full):	**Business Address** (in full):	

ACCIDENT

Date and time of Accident:	**Place of accident:**
State precisely how the accident occurred:	
Nature & extent of injuries :	**Name and Address of Witnesses** (if any):

DISABILITY

State the number of days you have been **ENTIRELY** confined to your bed, room or house by the direction of your Medical Attendant: -
(if you are still to your bed, room or house, state which on the following lines :)

To my BED for ..... **days from** ..... **to** .....

To my ROOM for ..... **days from** ..... **to** .....

To my House for ..... **days from** ..... **to** .....

I am now (insert "totally", "partially", or "not at all" as the case may be) ..... **disabled.**

If still disabled, how much longer the disability is likely to continue .....

I resume working on ..... **If not yet working, state approximate date when you expect to do so** .....

Give the Name and Address of the Medical Practitioner who is, or has been attending to you for this injury.

.....

Has he or any other practitioner attended to you previously for any illness or injury? If so, give particulars:

.....

Are you entitled to claim compensation for Accident Injury from any other Company/Companies? If so, give particulars:

.....

Do you wish to submit any proposition for an immediate settlement?

.....

I HEREBY DECLARE, that I have received the injuries above described by violent, accidental, external and visible means, and I claim compensation under the above Policy in respect thereof. I hereby warrant that the above statements and facts are true and that I have not withheld from the Company any material information in connection with this claim.

.....
Signature of Applicant

.....
Date

MEDICAL CERTIFICATE

FORM B

Claim No. **xxxxxxxxxxxxxxx**

In respect of the accident to .....

I DO HEREBY CERTIFY that I personally examined the injuries sustained by the above named in the accident described herein, and the said injuries are as follow:

1. Nature and extent of injuries

.....

.....

2. (a) State as fully as possible the cause of the accident

.....

.....

(b) Is the appearance of the injury consistent herewith?

.....

.....

3. Is there any connection between the present disablement and any disease or previous accident? If so, please give details:

.....

.....

4. Is surgical interference necessary or likely to become so? YES ☐ NO ☐ Please explain briefly.

.....

.....

5. What was your medical management?

.....

.....

6. Is the patient now, or was he at the time of the Accident, subject to or suffering from any illness or disease irrespective of the injury?

.....

.....

7. (a) Has the patient been confined to the house by your instructions?

.....

(b) If so, state inclusive dates.

..... to .....

8. Please state the date when the patient can resume to work.

.....

9. When did the patient first consult you for his condition?

.....

TEMPORARY TOTAL DISABLEMENT

I FURTHER CERTIFY that he has been wholly unable to leave his ("Bed, Bedroom, House") as mentioned overleaf and he has been totally disabled by the above Accident Injuries from ..... and that he is likely to be disabled for ..... (no. of days) from the present time.

TEMPORARY PARTIAL DISABLEMENT

I FURTHER CERTIFY that he has been partially disabled by the Above Accidental Injuries from ..... and that he is likely to be disabled from ..... to the present time.

....

Signature of Attending Physician Date

.....

.....

Address

TEMPORARY TOTAL DISABLEMENT
payable when an Insured is totally disabled temporarily from engaging in or giving attention to profession or occupation.

TEMPORARY PARTIAL DISABLEMENT
payable when an Insured is able to attend to some extent of his profession or occupation but unable to attend to a substantial part thereof.