

ACCIDENT AND ILLNESS CLAIM FORM



This form should be completed and returned without delay.
No claim can be admitted unless the Medical Certificate has been completed and signed.

PLEASE COMPLETE IN BLOCK CAPITALS

E-mail: icci.claims@insurancecorporation.com

P.O. Box 160
St. Peter Port,
Guernsey, GY1 4EY
Channel Islands

Telephone: 01481 713322
Facsimile: 01481 714426

www.insurancecorporation.com

P.O. Box 742
St. Helier,
Jersey, JE4 8ZZ
Channel Islands

Telephone: 01534 700200
Facsimile: 01534 768447

Policy No.

Broker/Agent

Name of Insured Mr, Mrs, Ms, Miss
Address
 Postcode
Telephone No. (Home) Telephone No. (Business)
Occupation/Business
Renewal date / /20

Employee (to be completed where a claim is being submitted in respect of an employee of the insured).

Name Age yrs
Home address
 Postcode
Occupation
Weekly earnings* £ Statutory sick pay/weekly Social Insurance Benefit £

* The average gross weekly amount paid by the Insured to the Employee during the twelve months preceding the accident or during any shorter period of employment.

Accidents

Date and time of accident

Date / /20 Time am/pm

Where did it occur?

Details of the cause

Injuries sustained

Has the injured person ever suffered from the same or a similar injury before? Yes No

Names and addresses of any witnesses

Illness

Nature of Illness

When did the illness commence

Has the person who is ill ever suffered from such illness before?

Yes

No

Medical attendant

Name and address of doctor attending the person suffering from the illness or injury

Name

Address

<input type="text"/>	<input type="text"/>
<input type="text"/>	Postcode

Name and address of his/her ordinary medical attendant

Name

Address

<input type="text"/>	<input type="text"/>
<input type="text"/>	Postcode

Disablement

Period during which the ill or injured person has been totally disabled for work as the sole and direct result of the accident or illness?

Is he/she still disabled?

Yes

No

If 'YES', when does he/she expect to return to work?

Have you previously claimed or received compensation under an accident and/or illness Policy?

Yes

No

If 'YES', please give particulars

Are you insured elsewhere?

Yes

No

If 'YES', give the name of each insurer, and the amount you are entitled to claim

I/We declare that the statements made are true to the best of my/our knowledge and belief and I/we claim the compensation payable under the Policy.

Signature of Insured

Date

PRIVATE AND CONFIDENTIAL

Medical Certificate to be completed by Employee's Doctor

It is understood that this certificate will be completed on the basis of your existing knowledge and without undertaking any further examination.

I Certify that _____

was injured or became ill on _____

the injuries are, or illness is _____

If the condition is complicated by any other disease or infirmity please give brief particulars:-

The patient is solely and directly totally disabled as a result of the injuries or illness and will be so disabled until:-

Signature and Qualifications _____ Date _____

Total Disablement occurs when the employee is **wholly** prevented from attending to his business or occupation.