PERSONAL ACCIDENT CLAIM FORM

(Definite and complete answers must be given to each question. The issue or acceptance of this form to or from you is neither to be regarded as an admission of liability nor as a waiver by the Company of any breach of the policy conditions which you may have committed.)

FOR OFFICIAL USE ONLY
Claim No:
Agency:
A/C Code No.:

INSURED DETAILS

Name in Full:	Policy No:	Age:
Business Address:	Telephone No:	Occupation:
Residence:	Home Telephone No:	Mobile Telephone No:

DETAILS OF ACCIDENT

Date & Time of Accident:	Place of Accident:
State how the accident and what you were doing at the time. (It is necessary that the fullest particulars be given. If space is insufficient, please attach separate sheet and continue.)	
State as precisely as you can, the injuries you have sustained.	
Given names and address of the doctor who witnessed the accident.	
(a) Given name and address of the doctor who attended to you after the accident. (b) Is he your usual medical attendant? If not, state reason why he was consulted.	(a) (b)
State whether you have been totally unable to perform any portion of your duties. If so, please give dates:	(a) In Bed for days from to (b) Confined to House days from to
Are you still totally unable to perform any portion of your duties?	
On what dates were you able to attend:	(a) To a portion of your usual business or occupation? (b) To the whole of your usual business or occupation?
State whether in respect of the accident you are entitled to receive compensation from any other source. If so, from what source and to what extent.	
Have you ever made a claim for compensation in respect of accidental injury from any insurer? If so, state name of company, amount and date received.	
If immediate settlement is desired, how much compensation do you wish to claim?	

I HEREBY DECLARE that I have received the injuries above described, and warrant the truth of the foregoing particulars in every respect, and agree that if I have made, or if I shall make any false or untrue statement, suppression or concealment, my right to compensation shall be absolutely forfeited. I further authorize the release of further medical information by the doctor in attendance should the Company require it.

Signature of Claimant: Date:

PLEASE HAVE YOUR MEDICAL ATTENDANT COMPLETE THE MEDICAL CERTIFICATE ATTACHED.

HSBC Insurance (Asia) Limited
21 Collyer Quay #12-01 HSBC Building Singapore 049320
Tel: (65) 6538 0880 Fax: (65) 6538 0660

Incorporated in the Hong Kong SAR with limited liability.

Attending Physician's Statement

This certificate is to be completed in full by a duly qualified and registered medical practitioner.

1	Name of Patient	
2	When did you first attend to the patient in consequence of the injuries sustained?	
3	Are you still in attendance?	
4	Are you his usual medical attendant? If so, how long have you known him, and for what other ailment have you treated him?	
5	Full particulars of injuries caused by the accident (if a limb or an eye state whether it is the left or right)	
6	a. Are you his symptoms (i) due exclusively to the accident, or (ii) traceable to disease, infirmity or any other cause? b. Has he ever suffered from a fit of any kind? c. Is there anything in his medical history which may have contributed, directly or indirectly, to the accident, or which may be likely to retard his recovery? d. Have you any reason to suppose that he was under the influence of intoxicants at the time of the accident?	a. (i) (ii) b. c. d.
7	How long has the patient been confined as a result of the accident:	(a) In Bed for days from to (b) Confined to House days from to
8	If still confined to bed or house, probable further period he will be confined.	
9	How long will the patient be (i) totally disabled and (ii) partially disable? (See note below)	(i) (ii)
10	Is there any disability now? If not, please give date of recovery.	
11	a) If the patient is now, in any way, attending to Business, on what day he first commenced doing so after the accident? b) If not, whether you consider patient fit to supervise or direct his Business or Occupation personally?	a) b)
12	Any further remarks …	

NOTE: TOTAL DISABLEMENT arises when the Patient is rendered completely incapable of attending to any part of his ordinary profession, business or vocation.
PARTIAL DISABLEMENT arises when the Patient is capable of attending to some portion of his ordinary profession, business or vocation including supervision.

I certify that I have satisfied myself by personal examination that the patient has sustained an accident causing injuries as above described, and to the best of my belief the foregoing statements are correct and should the Company require further medical information in connection with the above, I would release the said information upon the sanction of the patient.

Signature / Date

Qualifications:

Address: