



JN GENERAL INSURANCE COMPANY LIMITED
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PERSONAL ACCIDENT CLAIM FORM.

N.B. BOTH CLAIM FORM AND DOCTORS CERTIFICATE TO BE COMPLETED AND RETURNED IMMEDIATELY.

1. Policy Number: _____
 Name of Insured (in full) _____ Age: _____
 (Please state whether Mr. Mrs. or Miss)

Address { Private _____ Tel. No. _____
 Business _____ Tel. No. _____
 Occupation _____

2. The Accident. Date _____ Time _____ a.m. _____ p.m.
 Place _____

Description _____

Particulars of injuries _____

2. Names and Address of Witnesses _____

3. (a) Name and address of doctor in attendance _____

(b) Is he/she your usual doctor? _____

4. (a) How long have you been totally incapacitated from attending to your occupation? From _____ To _____

(b) How long have you been partially incapacitated in the sense of being necessarily prevented from attending to a substantial and essential part of your occupation?

From _____ To _____

5. Are you claiming under any other insurance? _____

If so, Please give Particulars _____

Signature of Insured:

Date:

If the Insured is unable to attend to this form, it should be completed on his behalf.

DOCTOR'S CERTIFICATE

Name of patient _____

2. When did he first consult you about this condition? _____

3. State condition from which patient is suffering _____

4. What is the cause? _____

5. Has he any illness or disease or physical infirmity from the condition mentioned above? If so please give details and indicate whether it will retard recovery _____

6. Is he totally incapacitated from attending to any part of his occupation? _____

(a) Date of commencement _____

(b) Probable duration from date of this certificate _____

(c) If total incapacity has ceased, date of cessation _____

7. Is he only partially incapacitated in the sense that he is unable to attend to a substantial and essential part of his occupation?

(a) Date of commencement _____

(b) Probable duration from date of this certificate _____

(c) If total incapacity has ceased, date of cessation _____

8. Is he on your advice confined to a house or hospital? _____

9. General remarks: _____

Signature _____

Qualifications _____

Address _____

Date _____