Personal Accident Claim Form

GlobeMed
Iraq

CLAIM NUMBER:

Issuance of this form does not imply acceptance of the liability

Please submit the complete filled form within 180 days of the accident

POLICY NUMBER: ________________________

DATE OF REGISTRATION: _____ /_____ /_____

NAME OF THE CLAIMANT: ___________________________

CLAIMANT ID: ____________________________

ADDRESS:

____

____

PHONE NUMBER: __________________________

OCCUPATION: _____________________________

DETAILS OF THE ACCIDENT:

____

NAME OF PATIENT IN ACCIDENT: _______________________________

RELATION WITH THE INSURED: ____

(ID / PASSPORT) NUMBER: _____________________

DATE OF THE ACCIDENT: ______________________

PLACE OF THE ACCIDENT: ________________________

NAMES AND ADDRESSES OF THE WITNESSES:

____

____

PARTICULARS IN THE ACCIDENT:

____

____

NATURE OF THE INJURY RECEIVED (WHICH LIMB/S, RIGHT OR LEFT):

____

____

NATURE OF DISABLEMENT (TEMPORARY OR PERMANENT):

____

____

NAME AND ADDRESS OF THE TREATING DOCTOR:

____

____

الحمراء للتأمين
Hamraa Insurance

GlobeMed Iraq

WHERE AND WHEN CAN A MEDICAL OFFCIR VISIT YOU (if necessary):

____

____

I/We hereby declare that the details given above are true and correct to the best of my belief and knowledge. In the event above information or any part thereof is found Incorrect, I agree that all right under the policy will be forfeited. I agree to provide additional Information to the Company if required. I will indemnify and hold harmless the Company due to any loss arising out of misstatement in this form and am willing if required, to make a statutory Declaration before a Justice of the Peace of the truth of the whole of the foregoing statement or any other statement I may make in connection with this claim.

Name of the witness: ______________________________

Signature: _________________________

Name of the claimed person: ________________________

Date: _____ /_____ /_____

Medical Certificate to be filled by the treating doctor

1. **Name of the claimant**
2. **Age**
3. **Nature and cause of the accident**
4. **Which limb affected?**
5. **Please confirm if the injury seems to be related to the accident?**
6. **When was the first visit of the patient?**
7. **Has the claimant been totally prevented from attending to any portion of his business? If so how long?**
8. **Is the claimant suffering from any disease or illness apart from his injury, if so please mention them?**
9. **Current condition of the patient**
10. **Do you consider this case as partial disability or total disability*?**

Having personally examined the above claimant, I certify the above statements are correct and that the injured person /claimant is necessary disabled by the accident referred to.

Signature: ________________________________ Stamp: ________________________________

Name: ________________________________ Specialty: ________________________________

Address: ________________________________

****Permanent total disability** means that patient is completely **disabled** as a result of injury **or** work-related illness and can no longer work in the capacity for which you were trained*

No.	Accidental Death / Document type	Yes/ No
1.	Duly filled, signed and stamped claim form	
2.	Original copy of Death certificate	
3.	Original copy of post mortem examination report(Forensic)	
4.	National ID / Passport	
5.	Police report	
6.	In case of Death happened inside the hospital please support us with copy of the medical file	

No.	Permanent Total Disability /Documents type	Yes/ No
1.	Duly filled, signed and stamped claim form	
2.	Complete treatment record like discharge summary , consultation papers with supporting investigations like x-rays , MRI, CT scan …etc.	
3.	Police report	
4.	National ID / Passport	

Please note all the above list is only indicative, insured \ claimant may have to submit additional information if required