



H Savy Insurance Co Ltd

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Personal Accident & Injury

Claim form

By lodging your claim with H Savy Insurance Limited, you hereby declare that the statements, facts and information herein contained are true and correct to your knowledge and or belief. That the statements, facts and information herein provided by you are complete and accurate. Failure to faithfully make full disclosure of the facts and information you know or ought to know may render you claim null and policy void.

Note: (1) The issue of this form does not imply admission of liability on the part of the Company.
(2) The INSURED is requested to answer all questions fully and return without delay.

Please use BLOCK CAPITALS and tick where appropriate

Insured

Title (Mr, Mrs, Miss, etc):	Surname:	Maiden Name:
Name:		
Address:	Email Address:	
(a) Trade or Business:	Telephone No:	
(b) Policy No:	Class of insurance:	
Period of Insurance:	From	To

Details of accident

Date:	Time:	(a.m. or p.m.)
Place:		
Brief details of how the accident happened:		
Did Police take particulars? If so, from which Police Station: (Please provide relevant statements, reports, etc from Victim, eye witness, police, etc)		

Details of personal injuries:

Name	Age	Occupation	Length of employment in present job	Current monthly salaries	Nature of Injuries sustained

Name and address of hospital/clinic attended:

Has employee/injured person resumed work? If so, when?

In your opinion who was negligent?

Have you in any way admitted liability?

Has any formal claim been made against you? If so, by whom and for what amount?

Note: Any correspondence received must be forwarded immediately to the Company.

Names of witnesses	Addresses of witnesses

Note: Please attach statement from Witnesses

Is there any other insurance policy in force? If so, please state Policy No:

Declaration

I/We declare the foregoing particulars to be true to the best of my/our knowledge and belief, and I/We further declare that I/We do not hold any other policy indemnifying me/us in respect of this accident.

Date:

Signature of Insured: