Advantage General
INSURANCE COMPANY Limited

Head Office: 4-6 Trafalgar Road, Kingston 5

Corporate Area Branches
Duke Street: 44 Duke St., Kgn.
New Kingston: 4-6 Trafalgar Rd., Kgn. 5
Portmore: Shop 31 Portmore Plaza, Portmore

Rural Branches
Black River: Shop 10 Marketside Plaza
Christiana: Midtown Shopping Centre
Mandeville: 30 Mandeville Plaza
May Pen: 48 Main St.
Montego Bay: 30 Market St.
Ocho Rios: Shop 5, 70 Main Street
Port Antonio: Shop 5, Goebel Plaza
Savanna-la-Mar: 33-35A Beckford Plaza.

PERSONAL ACCIDENT CLAIM FORM

Policy No.

Claim No.

Branch:

SECTION A: APPLICANT'S INFORMATION

Title *(e.g., Ms., Prof, Major, Dr.)*

First Name

Middle Initial

Surname

Home Address: Apt./Street *(No P.O. Boxes)*

Business Address

Business or Occupation

Any other please state

SECTION B:

Date

Time

Place of accident

Give particulars of the cause, and injuries sustained

SECTION C:

Name of Witness

Address of Witnesses of the accident

SECTION D:

Name of the Doctor Attending to you?

Address/Location of Doctor Attending to you?

SECTION E:

Kindly state when a Medical or Other Officer of the Company can visit you, if necessary

SECTION F:

State the period during which you have been totally disabled from attending to your business as the sole and direct result of the accident

From:

To:

Are you still totally disabled? ☐ Yes ☐ No

SECTION G:

Have you previously claimed or received compensation under an accident and/or Sickness policy? ☐ Yes ☐ No

If so, please give particulars

SECTION H:

Are you insured elsewhere? ☐ Yes ☐ No

If so, please give the name of each Company or Insurer, and amount you are entitled to claim

Company/Insurer

Entitled Amount

I the undersigned, Declare that, to the best of my knowledge and belief, the foregoing particulars are true and correct. I/We future declare the statements above can be upon in the contemplation of litigation proceedings which may arise.

Date: |_|_|_|_|_|_|_|_|

Signature: _____

PRIVATE AND CONFIDENTIAL

Medical Certificate to be complete by insured's Doctor

I certify that _____ was injured on _____ . Insured injuries are _____

_____

caused by _____

If insured injuries are complicated by any other conditions, please give details _____

_____

_____

_____

Insured is solely and directly _____ Disabled as a result of the injuries and will be disabled until _____

Signatures and Qualifications } _____

Total Disablement occurs when the insured is wholly prevented from attending to his business or occupation;
Partial Disablement when prevented from attending to a substantial portion thereof.