

CHARTIS INSURANCE IRELAND LIMITED

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Communication Workers' Union Personal Accident Cover for In benefit Members

CLAIM FORM

(If unable to complete personally, this form may be completed on behalf of Claimant.)

Name of Claimant in full: _____ Age: _____

Address: _____

Telephone Number: _____ (day) _____ (mobile)

Grade: _____ Staff No: _____

Date of Accident: _____ Date:ampm

Place: _____

How did it occur and where were you going at the time?

State as fully as possible what injuries you have suffered:

Name and address of usual medical attendant:

If usual doctor not consulted for these injuries, state why:

Has any other Doctor / Specialist been consulted? (if yes please give full details)

(if yes please give full details)

During what period have you been confined to Hospital (please submit evidence from Hospital).

From: _____ To: _____ (inclusive)

I hereby declare that the foregoing particulars are true in every respect.

Signature of Claimant: _____ Date: _____

PLEASE RETURN COMPLETED FORMS TO: CWU, 575 NORTH CIRCULAR ROAD, DUBLIN 1

The attending Doctor must complete this form at the Claimant's expense

When did you first attend the Claimant for the injuries suffered? _____

What was the DATE and CAUSE of the accident as far as known to you?

Are you the Claimant's usual medical attendant? _____

How long have you known the Claimant? _____ Are you still in attendance _____

What injuries were sustained? (If a hand or an arm, a foot or a leg, state whether it is the right of the left.)

If there is anything in the medical history which might have contributed to the occurrence of the accident, or which may in any way retard recovery?

On your instructions has the Claimant been confined to Hospital? _____

If yes- From: _____ To: _____ (inclusive)

Hospital Stamp →

If Claimant is still **TOTALLY** disabled, please state probable date of **PARTIAL** resumption of his/her **NORMAL** duties _____

If Claimant is **PARTIALLY** disabled, please state from when the probable date of **COMPLETE** recovery : From: _____ To: _____ (inclusive)

If Claimant is recovered, please state date of recovery: _____

General Remarks: _____

I certify that the foregoing particulars are correct.

Signature: _____ Qualification: _____

Address: _____

_____ Date: _____