GLICO LIFE INSURANCE CO. LTD, P.O.BOX 4251, ACCRA
TEL: 0302 246 140/0302 670 335

ACCIDENT CLAIM FORM

1. Name: _____ Policy No.: _____
2. Staff No: _____ Contact Number: _____
3. Email address: _____ Age: _____
4. Occupation: _____ Height: _____ Weight: _____
5. Employer's Name: _____
6. Employer's Address: _____ el No.: _____
7. Name of Ward: _____ D/Folder No.: _____
8. How did the Accident happen and what were you doing at the time? _____
   _____
9. Please give the name and address of any witnesses of the accident: _____
10. What injuries did you sustain? _____
11. What is the name and address of the Doctor attending to you? _____
12. Is s/he your regular Doctor? _____ From (date) _____ To (Date) _____
13. How long have you totally disabled? _____ From (date) _____ To (date) _____
14. How long have you been partially disabled? _____ From (date) _____ To (date) _____
15. When did you resume work after the accident? _____
16. Have you required medical or surgical treatment during the past five years? _____ If yes, please give details _____
    _____
    _____
17. Are you claiming under any other policy for this accident? _____
    If yes, please give details? _____

BANK DETAILS

a. Bank Name _____
b. Branch Name _____ Branch code : _____
c. Account Number: _____

DECLARATION

I declare that the above answers are true and correct to the best of my knowledge.

Signature: _____ Date: _____

CLAIMANT NOTICE:
STATEMENTS made shall be investigated. Any person who makes a claim based on any representation of the existence of a state of fact, knowing full well that the representation is false, stands the risk of having the claim repudiated as well as her/him being prosecuted for defrauding by false pretence contrary to section 131 of the Criminal Code Act 29.

MEDICAL CERTIFICATE

THIS CERTIFICATE IS TO BE COMPLETED BY A DULY QUALIFIED AND REGISTERED MEDICAL PRACTITIONER AT THE INSURED'S EXPENSE.

1. Name of Applicant: _____
2. Cause of Accident : _____
3. Nature of injury: _____
4. When did you first attend to the patient for injuries? _____
5. (a) Has the patient any disease, disability or physical defect apart from the effects of the accidents?

   _____

   If so, please give details? _____

   _____

   (b) If so, to what extent? _____

   (c) Was the accident attributed to it? _____

   (d) Is recovery retarded by it? _____
6. How long was the patient been totally disabled? _____

   From (date) _____ To (date) _____
7. How long was the patient been partially disabled? _____

   From (date) _____ To (date) _____
8. How long do you consider the disablement will continue? _____

   From (date) _____ To (date) _____

DETAILS OF DOCTOR:

Name of Doctor: _____

Name and Address of Hospital: _____

Tel No.: _____ Code: _____

Fax: _____ Email: _____

Doctors Signature: _____ Date: _____

Hospital Stamp: _____

CLAIMANT TO NOTE:

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