Elmo Insurance Ltd
Head Office: Abate Rigord Street, Ta' Xbiex, MSD 12, Malta.
Tel: 234 30000 (General) 21 345037 (Fax)

Group Personal Accident Claim Form

Preliminary particulars of accident

1 Insured

Policy No.

Name

Address

Postcode

Business

Tel. No.

2 Insured Person

Full Name

I.D. No.

Address

Postcode

Occupation

Age

Salary/Wages

3 Accident

Date

Time

am/pm

Place

How did the accident occur?

Injury sustained

Give name and address of any person who witnessed the accident

4 Disablement

When did incapacity start? Time am/pm

Is he detained in hospital? Yes ☐ No ☐

If so, give name of hospital?

Is he totally disable? Yes ☐ No ☐

How long is he likely to be totally disabled?

If he has returned to work give date of return

Has the Insured Person suffered from the same or a similar complaint before? Yes ☐ No ☐

If so, when? For how long?

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5 Medical Attendant

Name of Doctor now attending Insured Person

Address

Tel. No.

If not, give name of usual doctor

Address

Tel. No.

Declaration

I/We hereby declare that the information given on this form is true to the best of my/our knowledge and belief.

Signature

Date