Injury
Claim Form

ZURICH®

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All questions must be answered (Statement to be furnished by (or on behalf of) injured person) Claim No. _____

Please return this form to

Name of Insured _____

Postal address _____

_____

Occupation (describe fully) _____

Height _____ Weight _____ Age _____

1. How did the accident occur? (Please state fully)	
2. When and where did the accident occur?	
(a) Date	(a)
(b) Time	(b)
(c) Place	(c)
3. Who witnessed the occurrence?	
4. Nature of injuries?	
5. Have you been totally and completely disabled as a result of the injuries received?	
6. When did (a) total disablement commence?	(a)
(b) confinement to the house commence?	(b)
7. Are you at the present time (a) totally disabled?	(a)
(b) confined to the house?	(b)
8. When do you anticipate being able (a) to leave the house?	(a)
(b) to resume at least part of your duties or attend to some portion of your business?	(b)
9. Give name and address of the Doctor who attended you immediately after the accident	
10. (a) Who is your usual Medical Attendant?	(a)
(b) Have you consulted him in respect of your present injuries?	(b)
(c) When did you last consult him prior to this accident, and for what purpose?	(c)
11. Are you claiming under any other Policy or Policies in respect of this accident? If so, state name of Company or Companies	
12. State Policy No.	

Dated this _____ day of _____ 20 _____ Signature _____

Address _____

Please have Medical Certificate on page 2 completed.