شركة التأمين المتحدة
United Insurance Company

PERSONAL ACCIDENT - CLAIM FORM

IMPORTANT NOTES:

Insurers, their Agents and the Insurance Associations share information with each other to prevent fraudulent claims & for underwriting purposes. In the event of claim, some or all the information you supply to this form and in the claim form together with other information relating to the claim may be provided to other insurers, their agents and insurance associations. All questions must

PART: (A) POLICY HOLDER:

Name of insured ______ Policy No: ______

Address ______

Business/Occupation ______

Telephone/Mobile /Fax ______ Date of Birth ______

PART :(B) OCCURRENCE:

Date and Time of Incident: ______

Description of incident:

______

Nature of injury/illness: ______

Name & address of doctor who attended: ______

Have you sustained similar injury/illness before? YES ☐ NO ☐ If **YES**, when? ______

Name and address of usual doctor: ______

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During what period was the person totally disabled from attending to any art of his occupation /profession?

From: ____ To: ____ If total disablement continues,

Please attach a completed certificate by the injured person's doctor.

DECLARATION:

I/We declare that all particulars given are true and complete and claim the sum of Aed. __________________ as detailed above as supported by the enclosed documentary evidence.

Signature: ____ **Date** ____