شركة التأمين المتحدة
United Insurance Company

PUBLIC LIABILITY - 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.(*Please attach extra sheet if below space is not sufficient*)

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.

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 completed certificate by the injured person's doctor.

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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

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