PERSON ACCIDENT CLAIM FORM **CLAIM No.** _____

GK GENERAL INSURANCE COMPANY LIMITED

NEW KINGSTON Knutsford Boulevard | LIGUANEA Sovereign Ctr. | DOWNTOWN Duke Street | MANDEVILLE Midway Mall | MONTEGO BAY Fairview Shopping Ctr. | PORTMORE Portmore Town Ctr.

Toll Free: 1-888-429-5GKG (429-5454) | **Fax:** 876-968-1920 | **Email:** gkginfo@gkco.com | **Website:** www.gkgeneral.com

Name _____ Age _____ Years

TRN _____ E-mail Address _____

Address Private _____ Tel. No. _____

Business _____ Tel. No. _____

Business _____

Policy No _____ Date of Payment of last premium _____

Date of Accident _____ Time _____ a.m./p.m. Place _____

1. How did the accident happen? What were you doing at the time?	
2. What injuries have you sustained?	
3. Has the same part been injured previously?	
4. How long have you been totally or partially disabled from engaging in or attending to your usual business as the result of the injuries?	
5. How long have you been confined to:- Bed? House?	 From _____ to _____ From _____ to _____
6. Name and address of Doctor who is attending you. Is he your usual Doctor	
7. Have you required medical or surgical treatment during the past five years? If so, give particulars.	
8. Names and addresses of any witnesses of the Accident	
9. Are you claiming under any other insurance? If so, give particulars.	

I WARRANT that the above statement and particulars are correct and complete.

Signature _____ Date _____

This Form should be completed and returned within seven days
It is necessary that the questions overleaf be answered by a registered medical practitioner.

MEDICAL CERTIFICATE

1. Name of Patient	

2. What injuries has the Patient sustained?	
3. When were you first consulted?	
4. How long has the patient been totally or partially disabled from engaging in or attending to usual business as the result solely of the injuries?	Totally from _____ to _____ Partially from _____ to _____
How much longer do you consider such disablement will continue?	Totally from _____ to _____ Partially from _____ to _____
5. Has the Patient any disease or any defeat and if so of what nature?	
To what extent may recovery be affected thereby	

Signature _____ Qualifications _____

Address _____ Date _____