



Eloham Risk Solution

The Royal Group/Personal Care Claim Form

(PA & GPA)

INSURED

Name	<input type="text"/>	Policy No	<input type="text"/>
Address	<input type="text"/>	Present Age	<input type="text"/> Sex <input type="text"/>
Occupation	<input type="text"/>	Tel. No	<input type="text"/>
	<input type="text"/>	Fax No	<input type="text"/>

INJURY DETAILS

Date of accident Time Place

Name of injury

Have you suffered a similar injury before? YES NO
 If yes, when

Date when you became totally disable from attending usual business	<input type="text"/>	Date from which you became partially disabled	<input type="text"/>
When do you expect to resume business/work	<input type="text"/>	Give details if disablement is not due solely to the injury	<input style="height: 60px;" type="text"/>

OTHER INSURANCES

Insurers <input type="text"/>	Policy No <input type="text"/>
<input type="text"/>	

DOCTORS' DETAILS

Name of your usual doctor	<input type="text"/>	Address	<input type="text"/>
E-mail	<input type="text"/>	Tel.	<input type="text"/>
Name of the doctor attending to the injury	<input type="text"/>	Address	<input type="text"/>
E-mail	<input type="text"/>	Tel.	<input type="text"/>

DECLARATION

I Declare that the foregoing statements and particulars are true and complete.

Signature Date

Medical Report

(To be completed by a qualified and registered medical practitioner)

PATIENT

Name Sex

Name of injury

Date of first attended to injury

Details of similar injury, if any

What is likely to directly or indirectly contribute to retard recovery?

Period of total disability from attending to usual business
From To

Period of partial disability from attending to usual business
From To

When do you expect the patient to resume normal business?

Other Remarks

DOCTOR'S DECLARATION

I hereby declare that the above statements are true and complete.

Name Qualifications

Address

Signature Date