Accidental Injuries Claim Report – CLAIMANT'S STATEMENT FORM-PA

1) Full name of the assured POLICY NO:

Present Address

Nature of Duties Date of Birth

2)	a)	Give full description of injury and tell where, How, and when it happened	a)	
	b)	Describe any disease or infirmity which may Have caused this injury	b)	
3)	a)	Exact date when the injury occurred	a)	
	b)	Exact date injury resulted in loss of entire Sight or severance of limb	b)	
4)		HOSPITAL WHERE TREATED (Give complete names, addresses and dates of confinement)	From	to
5)		Give names and addresses of all physicians who have treated you for this injury		
6)		What other accident, sickness or disability insurance do you carry? (name companies, and describe benefits) societies, etc.		
7)		What other medical or surgical treatment has been received during the past five years? (Give dates, nature of illness or injuries and names and addresses of attending physicians and names and addressees of clinics or hospitals where treated)		
8)		What other organizations or companies have paid you indemnity for injuries suffered?		
9)		Period you were advised rest by physician.	From	to

I hereby authorize any hospital, physician or other person who has attended me to furnish to ALLIANCE INSURANCE (PSC) or its representatives, any information with respect to any sickness or injury, medical history, consultation, Prescription, or treatment, copies of all hospital or medical records and copies of all records of employees. I agree that a Photocopy of this authorization shall be considered as effective and valid as the original.

Date: ……

…… ……..

Signature of Attending Physician Signature of Policyholder

(Physician's statement on other side)

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name | Age

1)	Nature of injury (Describe complications if any)	
2)	When did symptoms first appear or accident happen?	Date
3)	When did patient first consult you for this condition?	Date
4)	a) Has patient ever had same or similar condition? b) If yes, state when and please describe	a) Yes ☐ No ☐ b)
5)	DISMEMBERMENT Describe actual place of severance	
6)	a) Is dismemberment or loss of sight due solely to Injuries sustained in the accident? b) If no, describe any disease or infirmity affecting injury?	a) Yes ☐ No ☐ b)
7)	LOSS OF SIGHT a) Is loss of sight entire and irrevocable? b) If yes, give exact date it occurred. c) If no, is it anticipated? d) When?	a) Yes ☐ No ☐ b) Date c) Yes ☐ No ☐ d) Approximate Date
8)	Is treatment contemplated to recover all or any part of this sight?	a) Yes ☐ No ☐
9)	a) Status of vision prior to injury b) Present status of vision (if none, state none) c) Describe any disease or infirmity affecting Sight prior to injury	a) Right eye / Left eye / b) Right eye / Left eye / c)
10	a) Nature of surgical procedure, if any (describe fully) b) Date performed c) Where performed	b) Date c) If in hospital In Patient ☐ Out Patient ☐
11)	Give dates of treatment	Hospital Home
12)	a) Is patient still under your care for this condition? b) If discharged, give date c) How many days rest do you recommend to the patient?	a) Yes ☐ No ☐ b) Date c)
13)	If patient hospitalized, give name and addresses of hospitals and dates of confinement	Hospital Address From To
14)	Give names and addresses of all other attending physicians	Name Address
15)	Is condition due to injury arising out of patient's employment?	Yes ☐ No ☐

DATE NAME & SIGNATURE (ATTENDING PHYSICIAN) DEGREE TELEPHONE NO.

FULL ADDRESS