Statement of Accident Insurance Claim

Policyholder Details

Full Name:

Address:

Contact Number:

Policy Number:

Accident Details

Date of Accident:

Time of Accident:

Location of Accident:

Describe How the Accident Happened:

Injury Details

Nature of Injury:

Treatment Received:

Hospital/Clinic Name:

Witness Information

Witness Name(s):

Witness Contact Information:

Declaration

☐ I hereby declare that the information provided above is true and complete to the best of my knowledge.

Signature:

Date:

Submit Claim