SHAHEEN INSURANCE COMPANY LIMITED

A Joint Venture of Shaheen Foundation-PAF, Hollard Insurance and FCSC

PERSONAL ACCIDENT INSURANCE CLAIM FORM

Name :	Sex	Age	Policy No.
Address:			Occupation
Amount of salary or wages (if not employed on that basis, give average earnings)	Salary or Wages Per month Rs……..		Average Earnings Per Month Rs…….
Date of Accident	Time of Accident A.M P.M		Place of Accident

Describe Accident in Detail

Are you making any other insurance or compensation claim as a result of this accident ? ☐ Yes ☐ No	Name of Company
Were you traveling?	If so :- From : To:

Conveyance (state name of train, bus number, airline flight number, etc.)

Describe injury

Attending Doctor Phone No	Doctor's Address

If hospitalized, give name and address of Hospital :

Totally and absolutely disabled From: To:	Partially disabled From: To:	Confined to Hospital From: To:

I, the above claimant, being duly sworn, depose and the say that the foregoing statement is complete and true to the best of my knowledge and belief, and agree that payment according to the terms of the policy, for the period of disability as herein indicated , shall be a full satisfaction and discharge of any and all claims, the cause of which originated prior to date hereof.

S i g n e d ……

D a t e……

A U T H O R I Z A T I O N

I hereby authorize any hospital, physician, or other person who has attended or examined me, to furnish to the Company, or its authorized representative , any and all information with respect to any injury, medical history, Consultation, prescription or treatment, and copies of all hospital or medical record .A photostat copy of this Authorization shall be considered as effective as valid as the original.

Signature of the Claimant ……...

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