ROGER RICH & Co
CHARTERED LOSS ADJUSTERS

T: +44 (0) 1608 641351
F: +44 (0) 1608 641176
E: enquires@rogerrich.co.uk

CLAIM FOR PERSONAL ACCIDENT/ SICKNESS BENEFITS

Certificate Number ____________________ Issue Date ____________________

YOUR DETAILS
Full Name of Insured Person Mr / Mrs / Miss ____

Full Address ____

____

____Postcode __________________

Occupation ______________________________ Date of Birth ____________________

Daytime Tel No __________________________ E-mail address ____________________

Injury Sustained/ Illness____

Date of Accident/ Onset of Illness __________________Time of Accident ____________am / pm

Place of Accident ____

Please give a description of how the accident occurred (continue of separate sheet if necessary)

____

____

Due solely to the injury/ illness have you been **TOTALLY** unable to perform **ANY** part of your business or occupation? YES / NO

If YES please give dates between which you were continuously disabled:

From the To the inclusive.

Have you been able to attend to some part of your business or occupation? YES / NO

If YES please give dates between which you were so disabled:

From the To the inclusive.

Briefly explain the extent to which you have been prevented by your disability from attending to your usual duties

____

ADDITIONAL INFORMATION

Please supply the following:-

Usual GP's Name & Address	Consultant/ Specialist's Name & Address
____	____
____	____
____	____
____	____
____	____

DECLARATION

I understand that the making of a fraudulent claim by providing untrue information is a criminal offence likely to lead to prosecution. I confirm that the information given on this form is, to the best of my knowledge and belief, true in every respect.

Signature of Insured Person ______________________________ Date ___________________

YOU MUST READ THE DECLARATION BEFORE SIGNING