GLICO GENERAL INSURANCE COMPANY
P.O. BOX 4251, ACCRA
TEL. (233-302) 244554/220220 FAX: 233-302-258211

GROUP PERSONAL ACCIDENT CLAIM FORM

THIS STATEMENT MUST BE FILLED AND RETURNED TO THE COMPANY WITHIN 28 DAYS AFTER THE ACCIDENT

NO CLAIM CAN BE ADMITTED UNLESS A MEDICAL CERTIFICATE IS FURNISHED.

1.	Name and address of the Policy Holder a. Name and address of injured person - if different from the above - b. Age next birthday of injured person	
2.	Present business, profession or occupation of injured person	
3.	State the nature of the accident, how it occurred, and what the injured person was doing at the time. This question must be answered in detail	
4.	Give time, date and where the accident occurred	a. Day ..... Date ..... b. Hour ..... 'O' clock in c. Place .....
5.	Give name and address of witness or witnesses of the accident	
6.	State, as fully as possible the injuries sustained Have injuries previously been sustained to the same part or parts?	a. b.
7.	Will any claim be made by the insured upon any other Company or Society in respect of this accident? If so, please state name(s) of all Companies or Societies	
8.	Was the Insured Person perfectly sober at the Time of the accident?	
9.	State when and where a Medical Officer of the Company can visit the injured person.	

10.	Give the name and address of the Medical Officer who attended the injured person on the happening of the accident	a.
	Is he the injured person's usual Medical Attendant?	b.
	Has he, or any other Medical man attended the Injured person previously for any serious illness Or injury? If so, give particulars	
11.	During what period has the injured person been confined to:	
	a. Bed	a.
	b. The House	b.
12.	Is the injured person totally unable to attend to any portion of his business?	

PAYMENT OF CLAIMS

Capital sums are payable immediately after satisfactory proofs of claim and title have been furnished. The temporary disablement allowance are payable in one sum immediately on the recovery of the injured person for a sum to be agreed upon.

DECLARATION BY THE POLICY HOLDER

I, the undersigned hereby declare that I am the person entitled to the benefit of the above policy and I solemnly assert that the answers I have given to the questions are true, and I hereby claim to be paid the sum of ..... for each week insured by the policy or the sum of ..... being the amount due to me form the ..... day of ..... 20 .....to the ..... day of ..... 20 ..... and I agree to accept the same in full satisfaction of all demands accrued or to accrue upon the Company in respect of all injuries or injuries results, direct and indirect, arising or to arise from the accident to which the above statements refer.

Note:
If the claimant is still disabled, and claims weekly allowance, he must fill the blank for a sum "for each week". If the claim is final, "total sum", date etc., must be stated.

Witness: ..... **Signature:** .....

Address: ..... **Date:** .....

.....

.....

.....