AIG Europe (Ireland) Limited
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# PERSONAL ACCIDENT CLAIM FORM

Please complete this form fully.
In the event of the claimant being unable to sign the form, it should be completed and signed by a responsible person on his/her behalf.
Return to AIG Europe immediately.

## 1. INSURED

Name _____

Address _____

Policy Number _____

Day Time Phone No. _____

Date Last Premium Paid _____

## 2. CLAIMANT

Name _____

Address _____

Date of Birth _____ Occupation _____

## 3. PARTICULARS OF ACCIDENT

Date and time of accident / / Time ____:____ ☐ AM ☐ PM

Place accident occurred _____

How did accident occur and what were you doing at the time?
(GIVE EXACT DETAILS)

_____

_____

_____

## 4. WITNESSES

Names, occupations and addresses of witnesses of the accident

_____

_____

Was the accident attended/investigated by the Gardaí? YES ☐ NO ☐
Name and station of investigating Garda

_____

## 5. INJURIES SUSTAINED

State fully the nature and extent of injuries

Have you ever suffered similar injuries? YES ☐ NO ☐

Details _____

_____

_____

## 6. MEDICAL DETAILS

Were you taken to hospital YES ☐ NO ☐

Which hospital _____

As an in patient or an out patient

from / / to / /

Give name and address of medical practitioner who attended you on your meeting with the accident

_____

_____

Is the doctor your usual medical practitioner YES ☐ NO ☐

How long have you been totally or partially disabled from engaging in or attending to your usual business as result of the injuries

Totally: from / / to / /

Partially: from / / to / /

## 7. OTHER INSURER

Are you claiming or entitled to claim compensation for the accident from any other source?
YES ☐ NO ☐

If so give particulars _____

_____

Do you have a personal accident policy with any other company or society?
YES ☐ NO ☐

Company _____

**I hereby declare the foregoing particulars to be true in every respect.**

**Signature** _____ **Date** _____

## MEDICAL AUTHORISATION

On production of this Authorisation, or a photocopy thereof, I authorise you to furnish AIG Europe with full reports on the condition of

_____

including the history of the complaint(s) which caused the above named to be admitted to hospital on

_____

Signature of claimant _____

Dated _____

**NOTE** ***If the claimant is a child this authorisation should be signed by a parent***

# MEDICAL CERTIFICATE

**To be completed by the attending Doctor, and supplied at the expense of the policyholder**

## 1.

Name of claimant _____

## 2.

When did the claimant first consult you in connection with this accident? _____

Please state fully the nature of the injuries sustained _____

_____

_____

Are the symptoms being suffered due to the accidentalone? _____

## 3.

How long has the claimant been totally or partially disabled from engaging in or attending to usual business as the result solely of the injuries?

Totally: From _____ To _____ Partially: From _____ To _____

Is the claimant suffering from any disease in addition to the present injuries, or has he/she any phtsical effect?

_____

If so, state the nature of same, and to what extent the recovery may be affected

_____

_____

## 4.

General Remarks _____

_____

_____

_____

_____

_____

I certify that to the best of my belief the above met with the accident referred to, and that the foregoing statements are correct.

**Signature** _____ **Qualification** _____

**Address** _____ **Date** / /