

PERSONAL ACCIDENT CLAIM FORM

Claim Number/s
PF

This form should be completed in block capitals by you and returned to your **Federation Representative** as soon as you know you will be absent from duty for over **SEVEN DAYS**.

ACK

FORM INS.1	RANK	WARRANT NO.	FIRST NAME	SURNAME
	SEX M F	DATE OF BIRTH / /19	STATION / BRANCH	

HOME ADDRESS _____

WHEN & WHERE THE ACCIDENT HAPPENED

DATE _____ PLACE _____ TIME _____

GIVE FULL DESCRIPTION
OF HOW ACCIDENT OCCURRED _____

DID INCAPACITY COMMENCE
IMMEDIATELY

IF NO, GIVE TIME & DATE
OF COMMENCEMENT

YES / NO

TIME _____ DATE _____

DETAILS OF THE INJURIES RECEIVED _____

MEDICAL CERTIFICATES should be produced to the Police Authority in the usual manner. **MEDICAL REPORT** Underwriters may subsequently require the claimant to supply at his/her own expense a report from his/her Doctor

DECLARATION

I, THE UNDERSIGNED, HEREBY DECLARE THAT I AM A SUBSCRIBING MEMBER TO THE ABOVE SCHEME AND TO THE BEST OF MY KNOWLEDGE THE ABOVE STATEMENTS ARE TRUE IN EVERY RESPECT AND ARE MADE WITHOUT RESERVATION.

DATE SIGNED

TYPE	PAYMENT TO BORDEREAUX	PAYMENTS ON ACCOUNT	DATE PAID	FINAL PAYMENT
FOR OFFICE USE				