THE INSURANCE COMPANY OF THE WEST INDIES LIMITED

13 Castle Street, Roseau, Dominica Tel: (767) 440-ICWI (4294)

PERSONAL ACCIDENT CLAIM FORM

To be completed by the Insured and his/her Doctor and returned
within seven (7) days of its receipt by the Insured

I hereby declare that all particulars to be given are true and correct and that no false or fraudulent statement will be made _____
Insured's Signature

NOTE: "N/A" means "Not Applicable"

1. Policy No.

2. (a) Name in full _____ (b) Date of Birth _____

(c) Present Address _____

(d) Present Profession or Occupation: _____

(e) Email Address: _____

3. (a) When and where did the accident occur? (Date and Time) _____

Place: _____

(b) How did it happen? (Full description to be given) _____

(c) Name & addresses of any witnesses to the accident. _____

(d) Name & address of Doctor who attended you immediately after the accident. _____

(e) Name & address of Doctor now attending you. _____

4. (a) Did the incapacity commence from the date of the accident? _____

(b) If not when did it commence? _____

5. Average weekly wages _____

6. Are you entitled to compensation from any other Company or any Club in respect of the injury for which you are claiming? If so, full particulars to be given. _____

7. Where can a Doctor or an Officer of the Company visit you if necessary? _____

MEDICAL REPORT. Any claim must be supported by a report on the reverse side of this form from the Insured's Medical Attendant, any fee for the report being payable by the Insured.

DECLARATION

I, the undersigned, hereby declare that I am the person referred to in the above statements, which are true in every respect and made without reservation and I hereby claim to be paid.

Delete (b) if total claim cannot now be made, or (a) if total claim can be made.

(a) compensation at the rate of _____ per week as from the _____ or

(b) the total sum of _____ which I agree to accept in settlement of my claim.

Date: _____ Signature: _____