GHANA UNION ASSURANCE LIFE COMPANY LIMITED

Head Office
F 828/1 Ringway Estates, Osu
P.O. Box GP 1185, Accra.
Tel: 0302 783021, 764674; Fax 233 302 764168
E-mail: life@gualife.com

ACCIDENT CLAIM FORM

Name of Claimant:……

Policy No……Age:……

Contact Address: ……

Tel. No.: ……

Occupation: ……

Employer's Name & Address: ……

……

Date of Accident: ……Time: ……Place: ……

Name of Ward (if admitted): ……OPD/Folder No.:……

Describe how the accident happened:……

……

……

What injuries did you sustain? ……

……

How long have you been totally disabled? From……To……
How long have you been partially disabled? From……To……

DECLARATION
I declare that the above answers are true and correct.

Date: ……Claimant's Signature: ……

NOTE: Your declarations are subject to further investigation by us.

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(This Certificate Is To Be Completed By A Registered Medical Practitioner)

Name of Patient.....

Cause of Accident.....

Nature of Injury.....

When did you first attend to Patient?.....

Has the Patient any disease, disability or defect apart from the effects of this accident?..... If Yes, give details.....

.....
Was the accident attributed to it?.....

How long has the Patient been totally disabled? From.....To.....
(Total disablement implies a situation whereby patient cannot pursue his/her usual occupation at all)

How long has the Patient been partially disabled? From.....To.....
(Partial disablement implies a situation whereby Patient cannot pursue his/her occupation full time)

Has the Patient fully recovered?.....If not, how long do you consider the

disablement will continue? From.....To.....

Name of Doctor.....

Name of Hospital.....

Address.....

Tel. No. .....

Doctor's Signature..... .....

Hospital Stamp:

NOTE: Statements and Declarations are subject to investigation by us