



12 Trafalgar Road, P.O. Box 408, Kingston 5
Employee Benefits Division
GROUP PERSONAL ACCIDENT CLAIM FORM
EB 208

GROUP PERSONAL ACCIDENT INSURANCE (NOTICE OF CLAIM must be given no later than 15 days following the accident or onset of illness). All Sections must be completed before claim is processed.

SECTION A

^{1a}GROUP POLICY #:	^{1b}MEMBER #:
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COMPANY/PROPOSER:

³EMPLOYEE - FULL NAME (PLEASE PRINT)	²TRN:
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ADDRESS:

DATE OF BIRTH: DD...../MM...../YY.....	DATE DISABILITY BEGAN: DD...../MM...../YY.....
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DATE OF ACCIDENT: DD...../MM...../YY.....	DATE LAST SEEN BY DOCTOR: DD...../MM...../YY.....
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DATE LAST ATTENDED WORK: DD...../MM...../YY.....	IS THIS YOUR FIRST CLAIM FOR DISABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
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WHEN DO YOU EXPECT TO RETURN TO WORK/OR WHEN DID YOU RETURN TO WORK?

DD...../MM...../YY.....

NATURE OF ACCIDENT/ILLNESS:

I certify that the above statements are correct and hereby authorize the Company, my doctor/hospital to give Guardian Life or their agents any additional information required in connection with this claim.

Employee's Signature

Date

SECTION B
EMPLOYER'S CERTIFICATE
(must be fully completed)

I am the Employer of the above named Employee, and certify that the named Employee was absent from work due to illness/accident:

From.....

To.....

Signature

Date

Position Held in Company:.....

Company's Stamp:

SECTION C
ATTENDING PHYSICIAN'S STATEMENT

^{1a}Group #: _____ ^{1b}Member #: _____ ²TRN: _____

N.B.: **THE PATIENT IS RESPONSIBLE FOR COMPLETION OF THIS FORM WITHOUT EXPENSE TO GUARDIAN LIFE LIMITED**

³NAME OF PATIENT/MEMBER: _____

DATE OF BIRTH: _____

PRESENT ADDRESS: _____

1. HISTORY

(a) When did accident happen?/disability commence? Day _____ Month _____ Year _____

(b) Date employee ceased attending work because of accident/disability: Day _____ Month _____ Year _____

(c) Has patient ever had same or similar condition? Yes No (If "Yes", state when and describe)

2. PRESENT CONDITION (Give details of Insured's present condition. Include results of X-Ray or Special Test)

(a) Is patient ambulatory? _____ Bed confined? _____ House confined? _____

Hospital confined? _____

3. DIAGNOSIS: _____

4. TREATMENT: _____

(a) Date of first visit: Day _____ Month _____ Year _____

(b) Date of last visit: Day _____ Month _____ Year _____

(c) Frequency of visits: Weekly Monthly Other

(d) When did you last examine the patient? Day _____ Month _____ Year _____

5. PROGRESS: Recovered Improved Unimproved Retrogressed

6. EXTENT OF DISABILITY:

(a) Is disability temporary or permanent? _____

(b) Is disability total? Yes No

^{1a}Group #: _____ ^{1 b}Member #: _____ ²TRN: _____

³NAME OF PATIENT/MEMBER: _____

(c) If disability is not total, please explain: _____

(d) Has employee resumed work? If no, please give prescribed dates for the patient's absence from work.

Start Date: _____ End Date: _____

If yes, please give the prescribed period for which the patient was absent from work.

Start Date: _____ End Date: _____

(e) For loss of limb/organ:

Limb/Organ Lost: _____

(i) Nature of loss: _____

(ii) Percentage of loss: _____

(iii) Is loss permanent? _____

Any additional comments by attending physician:

DATE

ATTENDING PHYSICIAN

ADDRESS

STAMP