Accident Insurance Claim Form

Policy Details

Policyholder Name: _____

Policy Number: _____

Date of Birth: _____

Contact Number: _____

Accident Details

Date of Accident: _____

Time of Accident: _____

Location: _____

Description of Incident:

_____

_____

Injuries Sustained

Describe the nature of injuries: _____

Did you receive emergency treatment? ☐ Yes ☐ No

If yes, provide details: _____

Claim Details

Total Amount Claimed: _____

Supporting Documents Submitted (check all that apply):

☐ Medical Reports

☐ Police Report

☐ Repair Estimates (if vehicle-related)

☐ Other: _____

Declaration and Authorization

☐ **I declare that the provided information is accurate.**

☐ **I authorize the insurer to obtain relevant details for claim verification.**

Name: _____

Signature: _____

Date: _____