MAGMA HDI
General Insurance Company Ltd.

FARMER'S PACKAGE POLICY (RETAIL)

CLAIM FORM - PERSONAL ACCIDENT INSURANCE

Policy No		Claim No.	
		Date of registration	
Regional/Branch Office Code			
Broker/Agent		Code	

5. a)Name of the insured person died/ injured in the accident b) Relationship with the employee/ member c) Employee/member identification no.	Self/Spouse/Children
6. a) Date of the Accident b) Time of the Accident c) Where it happened? d) Name & Address of the Witness	
7. How did the Accident occur?	
8. Nature of Injury received (if to limb or Eye state whether right or left)	
9. a) Nature of disablement b) Extent of disablement c) Period of temporary total disablement d) Present state of incapacity	(From……………to…………)
10. Name and address of Surgeon in attendance	
11. Where and when can a Medical Officer of our Company visit you, if necessary?	
12. a) Are you insured in any other Office or Offices granting compensation for accident? b) If so state name and address of company or Companies and amount of Insurance	

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I/We hereby declare that the foregoing statements are true in all respects and that I/We have not attempted to conceal from the company anything with which it ought to be made acquainted and also that if I/We have made or in any further declaration the Company may require shall make any false or fraudulent statement or any suppression, concealment or untrue averment whatever, the Policy shall be void and my/our right to compensation forfeited and am/are willing if required, to make a statutory Declaration before a Justice of the Peace of the truth of the whole of the foregoing statement or any other statement I/We may make in connection with this claim.

Witness: Name………………………………

Signature …………………………

Signature of the Insured…………………… Date …………