

## AIG EUROPE LIMITED

30 North Wall Quay, International Financial Services Centre, Dublin 1.

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## PERSONAL ACCIDENT CLAIM FORM

Please complete this form fully.  
In the event of the Claimant being unable to sign the form,  
it should be completed and signed by a responsible  
person on his/her behalf.  
Return to AIG immediately.



### 1. INSURED

Name \_\_\_\_\_

Address \_\_\_\_\_

Policy Number \_\_\_\_\_

Day Time Phone No. \_\_\_\_\_ E-mail \_\_\_\_\_

Date Last Premium Paid \_\_\_\_\_

### 2. CLAIMANT

Name \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_

### 3. PARTICULARS OF ACCIDENT

Date and time of Accident  /  /  Time \_\_\_\_\_:\_\_\_\_\_  AM  PM

Place accident occurred \_\_\_\_\_

How did the accident occur and what were you doing at the time?  
(GIVE EXACT DETAILS)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### 4. WITNESSES

Names, occupations and addresses of witnesses of the accident

\_\_\_\_\_

\_\_\_\_\_

Was the accident attended/investigated by the Gardaí? YES  NO   
Name and station of investigating Garda

\_\_\_\_\_

### 5. INJURIES SUSTAINED

State fully the nature and extent of injuries

Have you before suffered similar injuries? YES  NO

Details \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### 6. MEDICAL DETAILS

Were you taken to hospital YES  NO

Which hospital \_\_\_\_\_

As an in patient \_\_\_\_\_ or an out patient \_\_\_\_\_

from  /  /  to  /  /

Give name and address of medical practitioner who attended to you after  
the accident

\_\_\_\_\_

\_\_\_\_\_

Is the doctor your usual medical practitioner YES  NO

How long have you been totally or partially disabled from engaging in or  
attending to your usual business as a result of the injuries

Totally: from  /  /  to  /  /

Partially: from  /  /  to  /  /

### 7. OTHER INSURER

Are you claiming or entitled to claim compensation for the accident from  
any other source?

YES  NO

If so give particulars \_\_\_\_\_

\_\_\_\_\_

Do you have a personal accident policy with any other company or  
society?

YES  NO

Company \_\_\_\_\_

I hereby declare the foregoing particulars to be true in every respect.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## MEDICAL AUTHORISATION

On production of this Authorisation, or a photocopy hereof, I authorise you  
to furnish AIG Europe Limited with full reports on the condition of

\_\_\_\_\_

including the history of the complaint(s) which caused the above named  
to be admitted to hospital on

\_\_\_\_\_

Signature of claimant \_\_\_\_\_

Dated \_\_\_\_\_

**NOTE** If the claimant is a child this authorisation should be signed by a parent

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# MEDICAL CERTIFICATE

To be completed by the attending Doctor, and supplied at the expense of the insured

1.

Name of claimant \_\_\_\_\_

2.

When did the claimant first consult you in connection with this accident? \_\_\_\_\_

Please state fully the nature of the injuries sustained \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are the symptoms being suffered due to the accident alone? \_\_\_\_\_

3.

How long has the claimant been totally or partially disabled from engaging in or attending to usual business as the result solely of the injuries?

Totally: From \_\_\_\_\_ To \_\_\_\_\_ Partially: From \_\_\_\_\_ To \_\_\_\_\_

Is the claimant suffering from any disease in addition to the present injuries, or has he/she any physical defect?

\_\_\_\_\_

If so, state the nature of same, and to what extent the recovery may be affected by this

\_\_\_\_\_

\_\_\_\_\_

4.

General Remarks \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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I certify that to the best of my belief the claimant above met with the accident referred to herein, and that the foregoing statements are correct.

Signature \_\_\_\_\_ Qualification \_\_\_\_\_

Address \_\_\_\_\_ Date / /

AIG Europe Limited is authorised by the Prudential Regulation Authority of the United Kingdom, and is regulated by the Central Bank of Ireland for conduct of business rules.

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