# Accident Medical Claim Form

**Section 1: Personal Details**

Full Name

Date of Birth

Policy Number

Contact Number

Address

**Section 2: Accident Details**

Date of Accident

Time of Accident

Place of Accident

Description of Accident

**Section 3: Medical Details**

Nature of Injury

Treatment Received

Hospital/Clinic Name

Admission Date

Discharge Date

**Section 4: Claim Details**

Amount Claimed

Supporting Documents Provided (list)

**Section 5: Declaration**

☐ I hereby declare that the information given above is true and correct to the best of my knowledge.

Date

Signature