GUARDIAN LIFE CENTRE
12 TRAFALGAR ROAD, KINGSTON 5, P.O. BOX 408

Employee Benefits Division

GROUP STUDENT PERSONAL ACCIDENT CLAIM FORM
EB 209

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

SECTION A

[1a]**GROUP POLICY NUMBER:**	CERTIFICATE NUMBER:
SCHOOL/PROPOSER:	
[1b] **MEMBER NUMBER:**	[2] **MEMBER TRN:**
[3]**STUDENT: - FULL NAME (PLEASE PRINT)**	
ADDRESS:	
DATE OF BIRTH: DD……...../MM…..……../YY…..…..……..	DATE OF ACCIDENT: DD……..…/MM……......./YY…….….....
DATE FIRST SEEN BY DOCTOR: DD…......./MM…..…../YY.....	DATE LAST SEEN BY DOCTOR: DD…......./MM…..…../YY…..…..…
DATE LAST ATTENDED SCHOOL: DD……../MM……YY……	IS THIS YOUR FIRST CLAIM FOR ACCIDENT? ☐ YES ☐ NO
WHEN DO YOU EXPECT THE STUDENT TO RETURN TO SCHOOL/ WHEN DID THE STUDENT RETURN TO SCHOOL? DD……..……/MM……..…..…../YY……..……..	
NATURE OF ACCIDENT:	

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.

Signature of Parent/Guardian:_____ Date:_____

SECTION B

STUDENT'S CERTIFICATE
(must be fully completed)

I_____ certify that _____
(***Name of Authorised person)*** (***Name of Student)***

{Tick the appropriate box}

☐ was absent from school due to accident ☐ was not absent from school

From.....…..... To.....…….……..…….....

_____ _____
SIGNATURE OF AUTHORIZED PERSON DATE

School's Stamp:

[1a] **GROUP POLICY #:** [1b] **MEMBER #:**

[3] **MEMBER NAME:** [2] **MEMBER TRN:**

SECTION C
ATTENDING PHYSICIAN STATEMENT

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

NAME OF PATIENT:..... DATE OF BIRTH: .....

PRESENT
ADDRESS: .....

1. HISTORY

(a) When did accident happen? Day:_____Month_____ Year_____

(b) Date Student ceased attending school because of accident: Day_____ Month___Year___

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. LOSS OF LIMB/ORGAN:

Limb/Organ Lost: _____

(i) Nature of loss: _____

(ii) Percentage of loss: _____

(iii) Is loss permanent: _____

Any additional comment by attending physician:

_____

_____

_____

_____

_____ _____

DATE ATTENDING PHYSICIAN (SIGNATURE & STAMP)

_____

ADDRESS

For Official Use: Index by Group Number, Member Number, TRN and Name of Member.
Scan both pages of this document.