12 Trafalgar Road, P.O. Box 408, Kingston 5

Employee Benefits Division

GROUP PERSONAL ACCIDENT CLAIM FORM

EB 208

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

SECTION A

[1a]GROUP POLICY #:	[1b]MEMBER #:
COMPANY/PROPOSER:	
[3]EMPLOYEE - FULL NAME (PLEASE PRINT)	[2]TRN:
ADDRESS:	
DATE OF BIRTH: DD……...../MM……..………../YY…..………..	DATE DISABILITY BEGAN: DD……..…/MM……........./YY……..... ....
DATE OF ACCIDENT: DD……......./MM….......…../YY.........…….....	DATE LAST SEEN BY DOCTOR: DD….…../MM…........../YY...…… ....
DATE LAST ATTENDED WORK: DD...…../MM....../YY...…....	IS THIS YOUR FIRST CLAIM FOR DISABILITY? ☐ YES ☐ NO

WHEN DO YOU EXPECT TO RETURN TO WORK/OR WHEN DID YOU RETURN TO WORK?

DD……………………...……/MM……………………….....……/YY……………………………...………………...

NATURE OF ACCIDENT/ILLNESS:

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.

Employee's Signature ____________________ Date ____________________

SECTION B
EMPLOYER'S CERTIFICATE
(must be fully completed)

I am the Employer of the above named Employee, and certify that the named Employee was absent from work due to illness/accident:

From...………...........………………………………………………………..................................

To..…………..……………………………………………………………………………………….. ....

Signature ____________________ Date ____________________

Position Held in Company:..…………

Company's Stamp:

SECTION C

ATTENDING PHYSICIAN'S STATEMENT

[1a]**Group #:** ________________ [1b]**Member #:** ________________ [2]**TRN:** ________________________

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

[3]**NAME OF PATIENT/MEMBER:** ____

DATE OF BIRTH: ________________________

PRESENT ADDRESS: ____

1. HISTORY

   (a) When did accident happen?/disability commence? Day__________Month____________ Year____________

   (b) Date employee ceased attending work because of accident/disability: Day______ Month_______ Year _______

   (c) Has patient ever had same or similar condition? ☐ Yes ☐ No (If "Yes", state when and describe)

   ____

   ____

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. EXTENT OF DISABILITY:

   (a) Is disability temporary or permanent? ________________________________

   (b) Is disability total? ☐ Yes ☐ No

[1a]Group #: ____________________ [1 b]Member #: ____________________ [2]TRN: ____________________

[3]NAME OF PATIENT/MEMBER:. ____

(c) If disability is not total, please explain: ____

____

(d) Has employee resumed work? If no, please give prescribed dates for the patient's absence from work.

Start Date: ____________________ End Date: ____________________

If yes, please give the prescribed period for which the patient was absent from work.

Start Date: ____________________ End Date: ____________________

(e) For loss of limb/organ:

Limb/Organ Lost: ____

(i) Nature of loss: ____

(ii) Percentage of loss: ____

(iii) Is loss permanent? ____

Any additional comments by attending physician:

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____________________ ____________________
DATE ATTENDING PHYSICIAN

____
ADDRESS STAMP

PERSONAL ACCIDENT CLAIM FORM
GUARDIAN LIFE LIMITED
FORM # EB.E 0024/00208; 03/2010; 04/2014; 10/2016

For Official Use: Index by Group Number, Member Number, TRN and Name of Member.
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