Guardian Group 20th Anniversary
Guardian Life Limited

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:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

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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