

GROUP PERSONAL ACCIDENT SCHEME

CLAIM FORM

This Claim Form should be completed by the Insured Person or his/her eligible family member, as the case may be. Issue of this Claim Form does not tentamount to admission of liability by the Department

1.	Full N	ame	of th	e Ins	sure	d Pe	rson	l																				
2.	Offici	al De	signa	tion	of t	he Ir	sur	ed P	erso	n																		
3.	Offici	al Ad	dress	of t	he II	nsur	ed P	erso	n					•	ı	1			ı			T						
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4.	Full N	Ill Name of the Claimant																										
5.	Resid	entia	Add	ress	of t	he C	laim	ant																				<u>. </u>
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	DECLARATION																											

I hereby declare that the foregoing statement are true in all respect and that I have not concealed from the Department which ought to have been disclosed and I agree that if I have made or shall in any further declaration that the Department may require, make any false or fraudulent statement or suppress, conceal or aver untruly, my right to compensation shall be forfeit.

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Signature: Place:

Date: Name of Claimant: