ICEA LION
GENERAL INSURANCE

REPORT OF PERSONAL ACCIDENT FORM

Policy No. _____

This part to be completed by the Insured and forwarded to his (or her) Medical Attendant.

1. Full Name _____ Age _____
   (Please use Block Letters)
2. Address _____
3. Occupation (if more than one, state all) _____

4. State when accident happened	4. Date _____ 20 _____ Time _____ a.m.
5. State where accident happened	5. _____
6. Give full particulars of how the accident happened	6. _____
7. State precisely what injuries have been sustained	7. _____
8. Give names and addresses of any witnesses	8. _____
9. State whether you were perfectly sober when the accident happened?	9. _____
10. Did you receive any first aid attention? If so, by whom was it provided	10. _____
11. State particulars of disablement to the present date: (Please give exact dates) a. Confined to house by doctor's orders b. Otherwise totally disabled although able to go out of doors	From To a. _____ 20 _____ 20 _____ b. _____ 20 _____ 20 _____
12. Have you received any hospital treatment in connection with this accident? If so, state: a. Name of hospital and address b. Period you were an "In-Patient" c. Period you were an "Out-Patient" d. Whether you are still receiving hospital treatment	From To a. _____ 20 _____ 20 _____ b. _____ 20 _____ 20 _____ c. _____ 20 _____ 20 _____ d. _____ 20 _____ 20 _____
13. a. Are you now able to engage in any part or the whole of your usual occupation If so, b. State the date you were able to undertake part of it or c. The date you were able to undertake the whole of it	From To a. _____ 20 _____ 20 _____ b. _____ 20 _____ 20 _____ c. _____ 20 _____ 20 _____
14. State (a) The name of your present doctor (b) The date when he first attended you (c) If any other doctor has attended you for serious sickness or injury	From To a. _____ 20 _____ 20 _____ b. _____ 20 _____ 20 _____ c. _____ 20 _____ 20 _____

15. a. Are you entitled to claim compensation for the present accident from any other Company, Society or Club? b. if so, state particulars	a. _____ b. _____
Do you wish to effect a settlement of the Claim before recovery at a sum to be agreed upon? If so, do you submit any proposition for consideration?	_____ _____

I WARRANT the truth of the foregoing particulars in every respect and declare that:

1. I have received the injuries above describedby violent accidental external and visible means and claim compensation under the above Policy in respect thereof.
2. The conditions of my Insurance have been fully complied with.
3. I am willing, if required, to make a Statutory Declaration before a Justice of the Peace of the truth of the whole of the foregoing statement and of such other particulars as may be reasonably requested.

Signature of Claimant _____ Date _____

MEDICAL CRETIFICATE

(To be completed by a qualified medical practitioner)

1. Name of patient	_____
2. What injuries has the Patient sustained?	_____
3. When were you first consulted?	_____
4. How long has the patient been totally or partially disabled from engaging in or attending to your usual business as the result solely of the injuries?	Totally from _____ to _____ Partially from _____ to _____
5. On the basis of the Permanent Disability Scale shown below, do you consider that the patient has suffered any permanent disability?	_____
6. If so, what is the percentage?	_____
7. If the injury sustained by the patient is not specified in the Permanent Disability Scale, what percentage do you consider would be consistent with the percentages laid down in the Scale having regard to permanent loss or reduction in the earning capacity of the patient in any business or occupation?	_____ _____
8. Has the patient any disease or any physical defect and if so, of what nature?	_____
9. If so, has this aggravated in any way the present injury, and if so, what is the percentage of the aggravation?	_____

Name of Medical Practitioner _____ Signature _____

Qualifications _____ Address _____

Date _____

PERMANENT DISABLITY SCALE

INJURY	PERCENTAGE	INJURY	PERCENTAGE
1. Loss of both hands at or above wrists	100	24. one phalanx Loss of little finger	2
2. Loss of both feet at above the ankles	100	25. three phalanges	4
3. Loss of one hand at or above the wrist and of one foot at or above the ankle	100	26. two phalanges	3
4. Loss of all fingers and thumbs of both hands	100	27. one phalanx Loss of metacarpals	2
5. Total and irremediable blindness in both eyes	100	28. first or second (additional)	3
6. Total and irremediable paralysis Loss of arm	100	29. third fourth or fifth (additional) Loss of leg	2
7. at shoulder	60	30. at hip	70
8. between elbow and shoulder	50	31. between knee and hip	50
9. at elbow	47 1/2	32. below knee	35
10. between wrist and elbow	45	33. Loss of foot at ankle	32 1/2
11. Loss of hand at wrist	42 1/2	34 Loss of all toes of both feet Loss of great toe	15
12. Loss of four fingers and thumb of one hand	42 1/2	35. both phalanges	5
13. Loss of four fingers Loss of thumb	35	36. one phalanx	2
14. both phalanges	25	37. Loss of toe other than great toe (provided more than one toe is lost) – each	1
15. one phalanx Loss of index finger	10	38. Loss of one whole eye or total and irremediable blindness in one eye	30
16. three phalanges	10	39. Irremediable loss of sight (except perception of light) in one eye	30
17. two phalanges	8	40. Loss of lens of one eye	20
18. one phalanx Loss of middle finger	4	Total and irremediable deafness	
19. three phalanges	6	41. both ears	50
20. two phalanges	4	42. one ear	7
21. one phalanx Loss of ring finger	2		
22. three phalanges	5		
23. two phalanges	4		