KBIS PERSONNAL ACCIDENT CLAIM FORM

Section A Policy Holders Details
Your Name:
Policy No: **Personal Accident Scale:**

Section B Accident Details
1.Please give details of the person injured.

Name: .....Date of Birth:...../...../.....

Address:.....Occupation: .....

.....

.....

Postcode.....

2. Date of Accident...../...../.....

3. For what purpose was the animal being used at the time the accident occurred?

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4. Please give details of the injury.

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(Please continue on a separate sheet if necessary).

5. Was the injured person riding, handling or leading the animal? Yes ☐ No ☐

6. How did the Accident Happen? .....

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7. Was the injured wearing an approved hat at the time the accident occurred? Yes ☐ No ☐

British Standard No: .....

Section C Claim Details
1. Please tell us which benefit you are claiming for (see relevant table of benefits in your policy Terms & Conditions)

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2. For dental claims only, please state the amount you are claiming: ☐

Please note: Original invoices should be attached for dental claims

3. Do you wish to have the cheque made payable to the injured person? Yes ☐ No ☐

DECLARATION
I/WE DECLARE THAT ALL THE INFORMATION I/WE HAVE GIVEN IS TRUE AND COMPLETE
Signature of the policy holder: .....Date: ...../...../.....

I CONFIRM THAT KBIS MAY HAVE ALL REASONABLE ACCESS TO MY MEDICAL RECORDS.

Signature of the injured person: .....Date: ...../...../.....

Section D Medical/Dental Certificate

To be completed by the medical/dental practitioner at the policyholder's expense

1. Are you the injured persons' usual medical/dental attendant?

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2. When did you first attend the injured person for the injuries? ...../...../.....

3. What do you believe to be the cause of the injury?

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4. What is the nature and extent of the injuries sustained?

(a) Please state the area of the body affected (e.g. left/right/upper/lower/limbs/hand/feet/jaw)

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(b) Will the injuries give rise to:

(i) Permanent Loss of limb, eye or hearing? Yes ☐ No ☐

(ii) Permanent Total Disability entirely preventing the injured person from any type of work? Yes ☐ No ☐

If you have answered YES to either of the above questions please give full details:

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5. Are there any aspects of the injured person's previous medical/dental history which may have a bearing on this claim?

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6. Please state the total cost of the injured person's treatment or estimate if treatment not yet concluded.

(Deleting any treatment cost unrelated to the accident). ☐

7. Has treatment finished? Yes ☐ No ☐

8. Medical/Dental Practitioner's Name: .....

Address: .....

.....Postcode:.....

Signature:..... Date: ...../...../.....

Doctors/dental practice stamp (if applicable)