

## **Accidental Fracture Plus**

The accidental fracture claim must be submitted within 90 days of the accident. It must also be accompanied by the insured's birth certificate and a copy of the X-ray reports or any other form of medical imaging that confirms the fracture. The claimant is responsible for having this form completed and for any related charges.

A. Claimant's Statement		
A. Identification		
First name:	Last name:	Policy number:
Address:		
		ome: Cell.:
Relationship to claimant: San he/she is attending a recognized learning	ne person 🔲 spouse 🛛 child ng institution as a full-time student.	If the child is between <u>18 and 25 years of age</u> , provide proof that
B. Accident Date of accident (DD/MM/YYYY): Description of accident:		cident:
If the injury is the result of a motor veh Provide the name of the investigating p	nicle accident, was the insured the dr	
If the injury is the result of a work accid	lent, was an application for benefits i	made to a Workers' Compensation or other similar plan?   Yes  N
information about me, including othe employers or group insurance plan ad information regarding my claim.	er insurance companies, financial ir Iministrators, agents, representative n Life to provide necessary person nation with them	necessary information from individuals or organizations holding personal nstitutions, physicians, medical institutions and healthcare providers, es or brokers and all persons or organizations who may have personal onal information about me to the abovementioned individuals and the same value as the original.
Claimant's signature:		Date:
	B. Attending Physic	cian's Statement
Bone(s) fractured*:		Date diagnosed: (DD/MM/YYYY)////
*Provide a copy of X-ray reports or of a		
		ontributed fully or in part to this fracture?  Yes  No
If yes, provide details:		
Name of attending physician (in block le	etters) Address	
Telephone	Signature	Date
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