PERSONAL ACCIDENT INSURANCE CLAIM REPORT FORM

CLAIM FILE:

DATE OF LOSS:

ACCIDENT DETAILS:

INSURED: /
LAST NAME / Salutation & First Name

Name Insured ◉ Spouse ○ Child ○

COVERED LOSS: ☐ Death ☐ Dismemberment ☐ Sight ☐ Hearing & Speech ☐ Paraplegia

COVERED ACCIDENT: ☐ Airline ☐ Automobile ☐ Common Carrier ☐ Pedestrian ☐ Watercraft

ADDITIONAL NOTES:

CONTACT INFORMATION:

NAME:	**HOME PHONE:**
RELATIONSHIP:	**WORK PHONE:**
ADDRESS:	**FAX:**
CITY: **PROV:**	**EMAIL:**
POSTAL CODE:	

COVERAGE & BENEFICIARY INFORMATION:

Group Policy No.	Named Beneficiary	%	Relationship To Insured	Beneficiary Address	Sum Insured
GPAF-		%		Street _____ _____ City _____ Prov. _____ Postal Code _____	$
GPA -		%		Street _____ _____ City _____ Prov. _____ Postal Code _____	$

MEMBERSHIP VERIFICATION:

Club Code	Member No.	Expiry	Member Since	Member Type
				☐ Basic ☐ Plus

Verified By:	**Date:**

OPEN DATE: **OPENED BY:** **CLUB INSURANCE**

NOTES TO FILE: