

# Personal Accident Claim Form (Loss of Income)

Use this **personal accident claim form sample** to accurately document your loss of income following an injury. It provides a clear and concise format to help you submit your claim efficiently. Ensure all relevant details are included to support your compensation request.

## 1. Personal Details

|                 |                      |
|-----------------|----------------------|
| Full Name:      | <input type="text"/> |
| Address:        | <input type="text"/> |
| Contact Number: | <input type="text"/> |
| Policy Number:  | <input type="text"/> |

## 2. Incident Details

|                          |                      |
|--------------------------|----------------------|
| Date of Incident:        | <input type="text"/> |
| Description of Incident: | <input type="text"/> |

## 3. Medical Information

|                                  |                      |
|----------------------------------|----------------------|
| Nature of Injury:                | <input type="text"/> |
| Attending Doctor:                | <input type="text"/> |
| Hospital/Clinic:                 | <input type="text"/> |
| Period of Treatment (From - To): | <input type="text"/> |

## 4. Employment & Loss of Income Details

|  |                      |
|--|----------------------|
| Employer Name:                               | <input type="text"/> |
| Occupation:                                  | <input type="text"/> |
| Monthly Income:                              | <input type="text"/> |
| Period Absent from Work (From - To):         | <input type="text"/> |
| Total Loss of Income (Amount & Calculation): | <input type="text"/> |

Supporting Documents (Attach medical certificate, payslips, employer's letter, etc.):

Choose File

No file selected

## 5. Declaration

I hereby certify that the information provided above is accurate and complete to the best of my knowledge.

|                       |                      |
|-----------------------|----------------------|
| Claimant's Signature: | <input type="text"/> |
| Date:                 | <input type="text"/> |

Submit Claim