



if any, submitted).

- β) Name and Address of the Patient.
- γ) His age and occupation.
- δ) When did he first consult.
- ε) His general physical condition now.
- φ) Give full particulars of any other relevant aspect

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4. Amount claimed as damage from you :

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5. (a) Give the names and addresses of Person who witnessed the incident :

β) has the incident been reported to IMC or any other authority ?  
If so, state to whom and attach A copy of the report submitted. :

γ) What action, if any, has been taken by the authority ?

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Give particulars of other insurance if any, in respect of the same risk. :

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6. Has any claim been made upon you before.

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**I/We the above named, do hereby, to the best of my/our knowledge a belief, warrant the truth of the foregoing statements in every respect; and I/We agree that if I/We have made, or in any further declaration the Company may require in respect of the said accident shall make any false or fraudulent statement, or any suppression or concealment my/our claim shall be absolutely forfeited, and the Policy shall be null and void.**

Witness : Signature \_\_\_\_\_ Insured' s Signature  
\_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_