



- (b) Name and Address of the Patient.
  - (c) His age and occupation.
  - (d) When did he first consult.
  - (e) His general physical condition now.
  - (f) Give full particulars of any other relevant aspect
4. Amount claimed as damage from you :
5. (a) Give the names and addresses of Person who witnessed the incident :
- (b) has the incident been reported to IMC or any other authority ?  
If so, state to whom and attach A copy of the report submitted. :
- (c) What action, if any, has been taken by the authority ?
6. Give particulars of other insurance if any, in respect of the same risk. :
7. Has any claim been made upon you before.

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 \_\_\_\_\_