



Personal Accident / Sickness Claim Form

Policy Number	<input type="text"/>	AXA Office or Agent to whom you paid your premium	<input type="text"/>
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A	Name of Policyholder	<input type="text"/>	Claimants Date of Birth	<input type="text"/>
	Address	<input type="text"/>	Policyholder Tel. No.	<input type="text"/>
			Policyholder E-mail	<input type="text"/>
	Name of Claimant	<input type="text"/>	Claimants Occupation	<input type="text"/>
	Please advise to whom payment should be made if your claim is accepted			<input type="text"/>

B	Name of Doctor in attendance in respect of the injury or illness	<input type="text"/>
	Address of Doctor in attendance in respect of the injury or illness	<input type="text"/>
	Name of your usual Doctor	<input type="text"/>
	Address of your usual Doctor	<input type="text"/>
	From what date were you (a) totally disabled from attending to your usual business or occupation	<input type="text"/>
	(b) partially disabled from attending to your usual business or occupation	<input type="text"/>
	If still disabled, when do you expect to resume your usual business or occupation?	<input type="text"/>
	Is your disablement due solely to the injury or illness? Yes	<input type="text"/>
	No	<input type="text"/>
	If No, please give details	<input type="text"/>
	Were you suffering from any physical defects or infirmities prior to injury or illness?	<input type="text"/>
	Please give details of any benefit to which you maybe entitled under any other insurance policy or club scheme, with the name and address of the insurers or club	
	<input type="text"/>	

C To be answered in respect of an accident			
Date of accident	<input type="text"/>	Time	<input type="text"/>
Place of accident	<input type="text"/>		
Description of accident	<input type="text"/>		
Name and address of witnesses	<input type="text"/>		
Nature of injury	<input type="text"/>		
Have you suffered a similar injury before?	Yes	<input type="text"/>	No
If Yes, state when	<input type="text"/>		

D To be answered in respect of sickness			
Nature of sickness	<input type="text"/>		
Date when symptoms were first noticed	<input type="text"/>		
Have you suffered a similar illness before?	Yes	<input type="text"/>	No
If Yes, state when	<input type="text"/>		

I declare to AXA Insurance UK plc that the foregoing particulars are true and complete.			
I confirm I authorise Towergate MIA to handle my claim on behalf of the insurers.			
Signature	<input type="text"/>	Date	<input type="text"/>

Towergate MIA, Kings Court, London Road, Stevenage SG1 2GA
 Tel: 01438 739739 Fax: 01438 747465

Towergate MIA is a trading name of Towergate Underwriting Group Limited
 Registered Address: Towergate House, Eclipse Park, Sittingbourne Road, Maidstone, Kent. ME14 3EN
 Registered in England No. 4043759

Authorised and regulated by the Financial Services Authority



Medical Certificate

E Medical Certificate					
To be completed by a qualified and registered medical practitioner and supplied at the expense of the insured					
Name of patient					
Nature of injury or sickness					
Date of first attendance for this injury or sickness					
If there is any history of similar previous injury or sickness, please give details					
How long is the disablement likely to continue?					
Are there any factors which might have contributed to the injury or sickness or which might retard recovery					
Period of total disability	From		To		Inclusive
Period of partial disability	From		To		Inclusive
General Remarks					
Name					
Signature		Date			
Qualifications					
Address (please use practice stamp)					

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