

The strength behind your insurance

## **INCIDENT REPORT**

Name of Insured Person:	
Policy Number:	
Date of birth:	
Description:	
Time:	
Date (day/month/year):	
Place:	
Occurrence of incident:	
Hospital/clinic's name for the first visiting:	
Date (day/month/year):	
I, the undersigned, hereby declare to the best of my knowledge and belie and correct.	f that the particulars stated on this report to be true
I understand that if I fail to provide any information requested in this repaccept or process this claim.	port, it may result in the inability of the Company to
, Date (day/month/year): <b>Declarant</b>	Approved/confirmed
(full name and signature)	