Ind. No. 20. 10M-9-12.

PRELIMINARY NOTICE OF ACCIDENT.

TO BE FILLED OUT BY THE ASSURED.

NOTE.—Immediately after happening of accident this blank must be executed by claimant and physician and forwarded at once to the Company at New York, or to the duly authorized agent for the locality in which this policy is issued. Every question must be answered fully.

I .....age.....weight.....height.....**Policy Number**.....
insured in **THE FRANKFORT GENERAL INSURANCE CO.,** of Frankfort-on-the-Main, Germany, received an accidental bodily injury

on.....19.....at ....o'clock....M. and quit work on.....19.....at.....o'clock.....M.

and for the purpose of applying for such benefits as I may be entitled to, make answer to the following questions, which answers I hereby warrant to be absolutely true and correct, **without evasion or reservation, and I AM WILLING TO TESTIFY UNDER OATH** thereto if required.

1 **When did surgeon first attend you?**.....19.....**hour**.....**M. Where**.....
(At your home, his office, or elsewhere.)

2 When did you pay your last premium?.... .....19..... To whom?.....

3 **What was your occupation when injured?**.....
(Describe your usual duties.)

4 **What external and visible marks of such injury were there, if any?**.....
(State whether cut, bruise, or break, and where.)

5 **Where were you when the accident occurred?**.....
(State whether at home, on street, in shop, or elsewhere.)

6 **State here fully and precisely** what you were doing at the time and how the accident occurred?.....

.....

.....

7 **When do you expect to be able to perform some of your duties?**.....19.....

8 If paid at once without requiring further proofs, **what number of days' indemnity are you willing to accept** in full payment of claim for this injury?.....

9 Are you able to leave the house?.....Who were present when the accident occurred?.....
(Give names and addresses of two witnesses.)

.....

10 Do you work on a fixed salary, or commission, or by piece work?.....What are your average earnings therefrom?

$.....per..... ....Did you have steady employment when injured?.....

11 To what extent do you use narcotics, liquors, or drugs?.....

12 Are you carrying accident insurance in any other organization?.....
(Name the organizations and the amount carried in each.)

13 Have you made claim on this or any other organization before?.....
(Name organizations and the amount each paid you and dates of payment.)

14 Give surgeon's name..... Address.....

15 Give employer's name..... Address.....

Dated.....19.... **Claimant sign here**.....

Town.....Street.....County of.....State of.....
(Where you can be found while disabled.)

SURGEON'S

PRELIMINARY REPORT OF

ACCIDENT

Dated.....*19*....

Report of examination of Mr.....

1 (a) Do you know that he is the person described on reverse hereof? Answer.....(b) How long have you known him?

Ans.....(c) Are you his regular or family physician? Ans.....(d) Are you related to him? Ans.....

2 **When and where did you first examine claimant?**.....19.....hour.....M., at.....
(Your office, his home, or elsewhere)

3 Give temperature..... Pulse..... Respiration.....

4 **What is the precise location,** nature, and extent of the injury?.....
(Remove clothing if necessary. Describe the injury in detail.)

.....

5 **What marks or external evidences of injury** were there, if any?.....

6 **What operation, if any, did you perform,** and what treatment did you prescribe?.....

.....

7 **Does the injury totally disable** and prevent him from performing any and all duties pertaining to his occupation?.....

8 **How soon, in your opinion,** from date of injury, will he be able to perform some of his duties?.....days

9 **If not totally disabled,** what are the duties **he cannot** perform?.....

10 How many times have you attended him at his home for said injury, and on what dates?.....**Times. Dates**.....

.....

11 How many times have you treated him at your office for said injury, and on what dates?.....**Times. Dates**.....

.....

12 **Is he necessarily confined in the house?**.....Is the injury the sole cause of his disability?.....

13 Have you reported the claimant for any other company or organization?.....

14 Does the claimant use intoxicating liquors, drugs, or narcotics to excess, or to a degree to impair his health?.....

15 Has the claimant any chronic or constitutional disease or infirmity or any physical defect or deformity? If so, what?.....

.....

I Hereby Certify, That the foregoing answers and statements are absolutely true and correct, **without evasion or reservation,** and are made subsequent to a thorough examination of the claimant by me.

.....**Attending Physician.**

Graduate of..... **Street Address**.....