

**B A B P E R S O N A L A C C I D E N T C L A I M F O R M**

**NOTES TO ASSIST YOU:**

1. If a claimant is unable to claim personally, the claim form may be completed on his/her behalf.
2. To comply with the insurance policy conditions, this form **must** be submitted **within 21 days** of the accident.
3. The claim **must**:
  - a. Show your current BAB Insurance Certificate No.
  - b. Be countersigned by the Instructor in charge of the training session at the time of the incident.
  - c. Be sent by recorded delivery post to your Governing Body's Claims Officer, who is:  
Mrs Shirley Timms, 6 Halkingcroft, Langley, Slough SL3 7AT  
(tel: 01753 577878) (fax: 01753 577331)
4. The BAB Claims Officer will forward the claim form to the insurers, Perkins Slade, for their action. Once the claim is received by Perkins Slade they will deal directly with you on any further action required in processing the claim; this may include the requirement for you to provide – **at your own expense** – medical certificates from a doctor or hospital.

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BAB Ins Cert No	<input type="text"/>	Date of Issue	<input type="text"/>	Name of Association	<input type="text"/>
Name of Instructor in charge at the time of the incident			<input type="text"/>		
Your Full Name		<input type="text"/>		Date of Birth	<input type="text"/>
Your Home address          Post Code			Home Tel No	<input type="text"/>	
			Work Tel No	<input type="text"/>	
			E-mail address	<input type="text"/>	

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**Details of the Accident**

Date of accident	<input type="text"/>	Time of the accident	<input type="text"/>
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Where did it occur?

How did the accident happen? Describe precisely what you were doing at the time.  
For statistical purposes it is important that you give the fullest details.

What are your injuries?

Have you ever suffered a similar injury before? (tick box)

YES

NO

If "YES" please give details:

Give names and addresses of any witnesses:

1.	2.	3.
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**DECLARATION**

**C L A I M A N T :** I declare that these particulars are true in every respect.

Signature of Claimant

Date

**I N S T R U C T O R :** I declare that this accident occurred as stated.

Signature of Instructor

Date

**G O V E R N I N G B O D Y :** I declare that these particulars are true in every respect.

Signature of Governing  
Body  
(Secretary BAB)

Date

British Aikido Board Secretary to send this form by recorded delivery to:

**Perkins Slade, 3 Broadway, Broad St, Birmingham, B15 1BQ**