PERSONAL ACCIDENT INSURANCE - CLAIM FORM

- Please note that this Claim Form is issued without prejudice to the terms and conditions of the policy and issuance of this form should not be construed as admission of Liability.
- Please fill in all the blanks and give complete details of information asked for. In case space provided is found insufficient, a separate sheet may kindly be annexed.
- Please return this form, duly filled & signed, within 3 days, from the date of receipt of this claim form.

Policy Number:	**Claim No:**
Period of Insurance: From:	**To :**

1.	Name of the Insured (in full)	
2.	Address for communication P.B.No. P.C.No. Location	
	Tel. No GSM No. Fax No. Email Id	
3.	Name of the injured person & relationship with Proposar	
4.	Sum Insured	
5.	Table of Cover	
6.	Customer ID	
7.	Date of Birth & Age	
8.	Profession or Occupation	
9.	Date & Time of accident	
10.	Accident location (full address)	

11.	Brief description of the accident	
12.	Nature of Injury	
13.	Name and address of the Witness	
14.	Name and address of the Hospital/Nursing home /Doctor, where the injured person is treated	
15.	Whether the injured person discharged from the Hospital	
16.	Was the injured person under the influence of alcohol/drugs at the time of accident	Yes / No
17.	Disability type & period	
	a. Permanent Total Disablement • Nature • Percentage	
	b. Permanent Partial Disablement • Nature • Percentage	
	c. Temporary Total Disablement • No. of days • Date of accident • Date of fitness • (attach Dr. certificate) • Date of resuming duties	
	d. Death • Details of the nominee • Name & address	
18.	Have you made any claims in the past If yes, details	
19.	Are you insured under any other policy, If yes, provide details	

I/We hereby confirm that the responses and information provided in this form are true and correct. I/we also confirm having noted that any false disclosure of information OR failure to provide adequate disclosure of information shall render this claim invalid.

Place:
Date: **Signature of the Insured**

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MEDICAL CERTIFICATE

(To be completed by attending Doctor)

(Claim must be supported by medical evidence furnished by the insured at his / her expenses)

1.	Name of the injured person	
2.	Nature of the accident and details of injuries sustained	
3.	Does the cause of accident tally with the injuries noticed by you?	
4.	How long from the happening of the accident do you consider a) Permanent total disablement will last b) Permanent partial disablement will last c) Temporary total disablement will last d) Death	
5.	Date on which the injured person consulted.	
6.	Present condition	
7.	Are injuries solely due to the accident or traceable to any previous injuries/disease/ Infirmities?	
8.	How long was or will the injured person be not able to attend office/business	
9.	Was the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his/her condition?	
10.	Was the injured person hospitalized? If so, for what period.	
11.	What treatment was given? Whether Operation performed?	
12.	Was the injured person under the influence of intoxicants or drugs a the time of Accident	

Having personally examined the above named claimant, I certify that the above statements are correct and that the injured person / claimant are necessarily disabled by the accident referred to.

Name and address :
Regn. No. :
Date :

Doctor's Signature