

Personal Accident 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 answer all questions and give complete details of information asked for. Where the space provided is insufficient, a separate sheet(s) should be attached.
- Please return this form, duly completed and signed, within 3 days from the date of receipt of this claim form.

Policy details:	
Number	
Period of Insurance	From _____ To _____
Type	
Details of Insured	
a) Name of the insured in full	
b) Address of insured	
c) In case insurance through employer: Details of the business activity of the firm and number of years of operation	
Details of injured/deceased person:	
a) Name	
b) Post held	
c) Nature of job	
d) Nationality	
e) Sex and marital status	
f) Is he/she right-handed or left-handed by nature?	
g) Monthly wages/salary/income	
Details of incident:	
a) Day, date, and time	
b) Place of incident	
c) How did the incident happen? Give brief particulars	
d) Nature of injury	
e) Cause of injury/death	
f) Is this a road accident?	
g) Is a Third Party liable for the accident? Give name and address. (Attach police report)	
h) Attach evidence thereof	

In case of death compensation:	
a) Names and full address of beneficiaries	
b) Name(s) and address of legal heir(s)	
c) Name and address of the claimant, who bears Power of Attorney to receive death compensation	
d) Attach death certificate, all medical reports and other relevant documents in support of the above information	
In case of injury:	
a) When was he/she admitted into the hospital?	
b) When was he/she discharged from hospital?	
c) Attach all medical reports and other relevant documents in support of above information In r/o disability, medical board report indicating percentage of disability must be attached	
d) Name(s) and address of doctor(s) who attended to the injured/deceased person	
e) In case of insurance through employer: Attach incident report on the sequence of events s, signed by authorized signatory	
f) Any witness to the incident? If so, please attach witness statement	

DECLARATION:

I/We do further declare that, to the best of my/our knowledge and belief, all information provided is true and correct.

Signature of the Insured: _____

Name: _____

Date: _____

Stamp: _____