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CLAIM FORM - GROUP PERSONAL ACCIDENT

ISSUE OF THIS CLAIM FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

Policy Number _____ Period of Insurance from _____ to _____

Claim Number _____

A. DETAILS OF INSURED/CLAIMANT

Name of the Claimant: _____

Name of the Insured: _____

Relationship with Insured: _____

Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Pin Code: _____

Mobile Number : _____ Email ID: _____

B. DETAILS OF ACCIDENT/INCIDENCE

Date of Accident/Incidence: _____ Time of Loss: _____ A.M./P.M.

Cause of Accident/Incidence: _____

Details of Accident/Incidence: _____

Accident/Incidence Location Address: _____

City: _____ State: _____ Pin Code: _____

Mobile Number : _____ Email ID: _____

Were there any witness to the Accident/Incidence ☐ (Yes) ☐ (No), If 'Yes', _____

Name of Witness : _____

Address of Witness: _____

Mobile Number : _____ Email ID: _____

C. INFORMATION TO POLICE AUTHORITY

Has the loss been reported to an Police Authority ☐ (Yes) ☐ (No),

If 'No', reason for not reporting _____

If "Yes", provide details ☐ Police ☐ Other

Name of Authority: _____

First Information Report/MLC No: _____

Report Date: _____

Police station address: _____

Was the person moved to hospital immediately after the accident? ☐ (Yes) ☐ (No), If 'Yes', _____

Name of Hospital: _____

Address of Hospital: _____

Date of Admission: _____ Date of Discharge: _____

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D. DETAILS OF OTHER INSURANCE/INTEREST

Is the Accident/Incidence covered under any other Insurance ☐ (Yes) ☐ (No), If 'Yes', specify details and attach a copy of the policy

Name of Insurer: _____

Policy Issuance Office Location: _____

Policy No: _____ Period of Insurance: _____ Sum Insured (Rs): _____

If yes please specify: _____

E. For which benefit do you claim? [Please tick (✓) the appropriate box]

Benefit	Amount Claimed
☐ Accidental Death	
☐ Accidental Permanent Total Disability	
☐ Child Tuition Benefit	

F. ANY OTHER INFORMATION YOU MAY WISH TO PROVIDE

I/We, the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect; and I/We agree that if I/We have made, or make in any further declaration, the Company may require in respect of the said accident, any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited and the Policy shall be null and void, and all rights to recover there under in respect of past or future loss/accident shall be forfeited.

Place: _____ Signature: _____

Date: _____ Name of Insured/Claimant: _____

Annexure I: TO BE COMPLETED BY NOMINEE IN THE EVENT OF INSURED'S DEATH

Name of Nominee: _____

Relationship with Insured: _____ Date of Birth: _____ Age: _____

Address: _____

Mobile Number: _____ Email ID: _____

*If nominee is minor, kindly provide the Legal Guardian details

Name of Guardian: _____

Relationship with Insured: _____ Date of Birth: _____

Address: _____

Contact Details:

Mobile Number : _____ Email ID: _____

I/We hereby declare and warrant the truth of the foregoing particulars in every respect. I /We agree that if I/We have made or shall make false or untrue statement, suppression or concealment, my/our right to compensation shall be forfeited.

I/We also hereby declare that I am/we are accepting the amount in full discharge of your obligations under the policy to the Insured Person and/or his/her legal heirs. I/we will hold you indemnified in the event of any claim under this policy being made against you by any other person or persons.

Place: _____ Signature: _____

Date: _____ Name of nominee: _____

Insurance is the subject matter of solicitation. For more details on risk factors, terms and conditions, please read sales brochure carefully before concluding a sale.

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Annexure II: MEDICAL CERTIFICATE: To be filled by Treating Doctor

Name and address of Injured: _____

Gender: ☐ (Male) ☐ (Female), Date of Birth: _____ Age: _____

Nature of the Accident/Incident and Details of Injuries Sustained: _____

_____

Cause of accident/Incident: _____

Are the injuries: A) Solely due to accident /incident: ☐ (Yes) ☐ (No),

B) Traceable to any Disease : ☐ (Yes) ☐ (No), If 'Yes ',

Give details: _____

C) Traceable to any previous injury: ☐ (Yes) ☐ (No), If 'Yes ',

Give details: _____

Was insured under influence of drugs/intoxicants at the time of accident: ☐ (Yes) ☐ (No),

Is the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his/her condition or

delay improvement: ☐ (Yes) ☐ (No), If 'Yes ',

Give details: _____

Details of Disablement: _____

Nature of Disablement:

a) Permanent Total Disablement: ☐ (Yes) ☐ (No)

b) Permanent partial Disablement: ☐ (Yes) ☐ (No), If 'Yes ',

Please specify the percentage: _____

a) Temporary Total Disablement: ☐ (Yes) ☐ (No), If 'Yes',

Please specify the Duration of Temporary Total Disability _____

Details of Treatment given: _____

According to you, how long should the injured person be confined to bed/house as the direct and sole consequence of the injury sustained?

From Date: _____ To Date: _____

During this period will the injured person be able to attend to his/her normal duties? ☐ (Yes) ☐ (No),

If 'Yes', From Date: _____

If 'No' Please state probable date of his/her being able to attend to/his normal duties Date: _____

I certify that I have examined the above-named Insured. The above statements are correct and that the injured person is necessarily disabled by the accident referred to. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Name of treating Doctor: _____

Qualifications: _____ Registration No: _____

Signature of the Doctor: _____ Date: _____

Address: _____

Mobile Number : _____ Email ID: _____

Stamp & Signature of the Doctor: _____

G. ENCLOSURES CHECKLIST

1. Accidental Death

- ☐ Claim form duly signed
- ☐ Policy copy
- ☐ Claim Intimation
- ☐ FIR/MLC Copy/Spot Panchnama/Inquest Panchnama
- ☐ Death Certificate
- ☐ Post Mortem Report
- ☐ Final Police Report
- ☐ Original legal heir certificate (in case nomination has not been filed by deceased)
- ☐ Any other related documents

2. Accidental Permanent Total Disablement

- ☐ Claim form duly signed
- ☐ Policy copy
- ☐ Claim Intimation
- ☐ FIR/MLC Copy/Spot Panchnama/Inquest Panchnama
- ☐ Investigation reports
- ☐ Medical certificate
- ☐ Nominee certificate
- ☐ Disability Certificate
- ☐ Photograph of the injured with reflecting disablement
- ☐ Any other related documents

3. Child Tuition Benefit

- ☐ Same as the documents Listed under section 1, 2 and
- ☐ Child birth certificate
- ☐ Child education ID card
- ☐ Any other related documents