COMPULSORY PERSONAL ACCIDENT (OWNER-DRIVER) UNDER MOTOR INSURANCE POLICIES

CLAIM FORM

Please fill this form COMPLETELY. The issue of this form is not to be taken as an admission of liability.

Policy No.:_____ Claim No.:_____

1. Details of Policy Holder

Insured / Claimant's Name:_____

Address:_____

_____

City:_____ Pin Code:_____ State:_____

Mobile No.:_____ Landline No.:_____

Email ID:_____

2. Loss Details

Date of Loss: DD/MM/YYYY Time of Loss : HH/MM AM/PM Place of Loss :_____

Description of Loss:_____

_____

Details of Vehicle in which Insured was Mounting into / Dismounting from or travelling at the time of accident:

Vehicle Registration Number:_____ Chassis No.:_____

3. Details of Insured's Driving License

Name of Driver: Mr./Ms./Mrs._____

Driving License (DL) No.:_____ Issuing RTO:_____

Authorized to Drive:_____ Valid up to:_____

4. Police Notification Details

Police report lodged: ☐ Yes ☐ No If Yes, Report No.:_____ Date: DD/MM/YYYY

Police Station:_____ District:_____

5. Injury Details

Nature of Injury: ☐ Permanent Disablement ☐ Partial Disablement ☐ Death

Declaration

I/We agree to provide additional information to the Company, if required. I/We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and if I/We have made, or in any further declaration the Company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, the policy shall be void and all rights to recover thereunder in respect of past or future accidents shall be forfeited. I understand that the Company reserves the right of verification of facts and documents relating to the policy and claim.

Data Privacy Notice

I/We hereby provide consent to the Company for collecting/retaining any information relating to Me/Us including Sensitive Personal Information ("hereinafter cumulatively referred to as "INFORMATION"), that is either available with the Company or disclosed by Me/Us while obtaining the policy of Insurance from the company or otherwise. I/We further understand that the Company may use the INFORMATION for servicing the Insurance policy obtained by Me/Us and for same may share the INFORMATION with any reinsurer, insurance association, medical authorities, other Insurers, statutory authorities, court, governmental body, regulator etc., or with services provider(s) engaged by the Company for servicing the Insurance policy, underwriting the risk, settlement of claim etc. without obtaining our specific consent for such sharing and we hereby provide our consent to Company for same.

I/We understand that whenever I/We would like to update/correct the INFORMATION, we will intimate the Company for the same, so as to enable the Company to amend/correct the INFORMATION accordingly. Further in the event I/We would like to withdraw My/Our consent provided herein, I/We would intimate the Company of the same in writing and also understand that, in the event of such withdrawal by Me/Us, the Company reserves the right to not provide Me/Us the Services for which it has sought the INFORMATION.

Date: DD/MM/YYYY

_____

Signature of Insured / Nominee

Place:_____