GROUP PERSONAL ACCIDENT INSURANCE POLICY CLAIM FORM

The issue of this form is not to be taken as an Admission of liability.
CLAIM NO._____

SECTION I (TO BE FILLED IN FOR ALL CLAIMS)

1. (a) Insured's Name _____

   (b) Address: _____
   _____
   _____
   _____

   (C) Age: _____

2. (a) Policy No. _____
   (b) Period From _____to _____
   (c) Issued at _____

3. (a) Particulars of accident: Date Time Place
   Whether reported to Police Yes/No
   (b) Details

4. (a) Were you removed to hospital immediately after the accident? Yes/No
   (b) If yes, address of the hospital

5. (a) Do you have any other Group Personal Accident Policy? Yes/ No
   (i) If yes, Name of the company: _____
   (ii) Policy No.: _____
   (iii) Period _____ yrs From _____ to _____
   (iv) Issued at: _____
   (b) Are you entitled to recover medical/hospitalisation expenses under any other medical/hospitalisation scheme?
   If yes, (i) Nature of scheme:
   (ii) Amount paid or payable:

SECTION II (TO BE FILLED IN BY HOSPITAL AUTHORITIES)

1. Name and address of the hospital: _____
   _____
2. Date of admission: _____
3. Date of Discharge: _____
4. (a) Nature of injury: _____
   (b) Particulars of treatment: _____
5. Has the accident resulted into loss of hand/s or foot/feet or eye/s permanent disability of any other type which may prevent the insured from engaging in or being occupied with or giving attention to any employment or occupation whatsoever?
   If yes, please give details
6. Hospital expenses (Please attach original bills)

Date _____
Rubber Stamp of Hospital

Signature of the Competent Authority
Of Hospital/Nursing Home

Designation _____

SECTION III (TO BE COMPLETED BY NOMINEE IN THE EVENT OF INSURED'S DEATH)

Details of Nominee

(a) Full Name: _____

(b) Address: _____

_____

(c) Age: _____

(d) Relationship with the deceased: _____

Date: _____

_____
Signature of the Nominee

Please attach the following documents:

1. Death certificate
2. Post Mortem Report
3. Original Policy document with receipt

Declaration to be signed by the Insured/Claimant or by a Nominee (in the event of insured's death)

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 if, shall make false or untrue statement, suppression or concealment, my/our right to compensation shall be forfeited.

I/WE ALSO HERE DECLARE that I am /we are accepting the amount in full discharge of your obligations under the policy to the insured and/or his/her legal heirs and 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.

Date _____ Signature _____