

CLAIM FORM FOR PERSONAL ACCIDENT INSURANCE
 (The issue of this form is not to be taken as an Admission of Liability)

PLEASE ANSWER ALL QUESTIONS FULLY

1.	DETAILS OF INSURED	
(I)	Name	
(ii)	Address of Correspondence	
(iii)	Contact No.	
2.	DETAILS OF INJURED/DECEASED PERSON	
(I)	Name	
(ii)	Address	
(iii)	Age	
(iv)	Designation	
(v)	Date & time of injury/death	
(vi)	Place of injury/death	
(vii)	Details of the accident	
(viii)	Whether reported to Policy	Yes/No
(ix)	If yes then name and address of Policy Station	
3.	Was the injured/deceased person moved to hospital immediately after the accident? If yes, name and address of the Hospital	Yes/No
4.	Do you have any other Personal Accident Policy If Yes, please give:	
(i)	Address of the issuing office	

(ii)	Policy No.	
(iii)	Period	

Declaration:

I hereby agree, affirm and declare that:

(a) The statements/information given/stated by me/us in this claim form are true, correct and complete.

(b) No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.

(c) If I have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I shall not be entitled to all/any rights to recover there under in respect of any or all claims, past, present or future.

(d) The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.

Place: _____

Date: _____

Signature of the Injured Person