





Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_

- Hospital(s)  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_

**6. CONTACT DETAILS – where and when can our representative may visit you, if necessary.\***

Address where Available: \_\_\_\_\_  
 Phone No. \_\_\_\_\_

**7. Please indicate the appropriate section under which you are claiming along with the amount\***

Coverage	Amount (Rs.)
Accidental Death	
Permanent Total Disablement	
Transportation charges	
Ambulance Charges	
Education Fund	

**8. Period of disability - applicable for claim under Temporary total disability\***

(The period should be the actual days when fully confined to bed on Medical Advice)

From: (dd/mm/yyyy) To: dd/mm/yyyy)

**9. Past Insurance History\***

- Have you made any claims in the past ? YES/NO
- If YES, please give details including accident and Insurance details

Name of Ins co	Policy no.	Capital Insured	Sum	Nature of claim	Status of the claim

**10. Are you currently insured under any other Policy?\***

YES/NO

If YES, please give full details

Name of Insurance co.	Policy no.	Capital Insured	Sum	Details of claim lodged	Status of the claim

**11. Have the Police Authorities been informed of this accident?. If yes, please specify the name of the Police station and the FIR \_\_\_\_\_**

I/We hereby declare that the foregoing statements made by me/us are true in all respects, that I/We have not attempted to conceal from the Company anything with which it ought to be made acquainted and that if I/We have made or in any further declaration the Company may require shall make any false or fraudulent statement or untrue averment whatever, the policy shall be void and my/our right to compensation forfeited. I /We are willing if required, to make and provide to the company a statutory



declaration of the whole of the foregoing statement or of any other statement made in connection with this claim

**Date:**

**Place:**

**Signature of the Insured/Insured Person**

**ATTENDING PHYSICIAN'S STATEMENT**

**PLEASE ANSWER ALL QUESTIONS**

1. Name Of the Injured Person: \_\_\_\_\_  
Age: \_\_\_\_\_
2. Nature of the Accident and Details of Injuries sustained. Please specify the parts of the body. If injury sustained in eye or limb, specify left or right. \_\_\_\_\_
3. Does the Cause of Accident as stated by the Claimant tally with the Injuries noticed by you?  
\_\_\_\_\_
4. Are the Injuries solely due to the accident or traceable to any previous injuries/ disease/ infirmities?  
\_\_\_\_\_
5. Was the Injured Person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition. \_\_\_\_\_
6. Was Injured Person under the influence of intoxicants or drugs at the time of accident ?  
\_\_\_\_\_
7. Was the Injured Person hospitalized? If so for what period?  
From ----- (dd/mm/yyyy) To ----- (dd/mm/yyyy)
8. Details of treatment and Operations (if any) performed: \_\_\_\_\_
9. Give all dates of treatment:  
Home: From ----- (dd/mm/yyyy) To ----- (dd/mm/yyyy)  
Clinic/ Hospital: From ----- (dd/mm/yyyy) To ----- (dd/mm/yyyy)
10. Please fill one of the following to indicate the nature of the disability.

Nature of disability as per the attending doctor	Please specify against the appropriate nature of disability
Temporary Total Disablement	
Permanent Total Disablement	
Permanent Partial Disablement	



11. In case of Temporary Total disability how long was or will the claimant be totally disabled from current occupation?

From -----(dd/mm/yyyy) To -----(dd/mm/yyyy)

**Doctors Name:** \_\_\_\_\_  
**Regn No.** \_\_\_\_\_  
**Address :** \_\_\_\_\_

**Doctor's Signature**  
**Date:** \_\_\_\_\_