

THE NEW INDIA ASSOURANCE COMPANY LIMITED

(Redg. & Head Office : New India Assurance Building, 87, M.G. Road, Fort, Mumbai – 400 001.)

Policy No. _____

Claim No. _____

Claim Form
Personal Accident Insurance

The issue of the Form is not to be taken as admission of liability

1. INSURED a) Name b) Address	
2. DECEASED/INJURED PERSON a) Name b) Address c) Occupation d) Age in completed years	
3. ACCIDENT DETAILS : a) When & Where did the accident happen? Please give date/time/place b) Give Full description the accident, its cause and injuries sustained c) Whether the accident has been reported to police ? If, yes Name of police Station and attach an attested copy of FIR d) In Case of death, name of hospital, where postmortem Was conducted (attach attested copy of post mortem Report and Death Certificate.) e) Name and address of witnesses	
4. TREATMENT a) Give details of medical attention given and the name/Address of the Medical Practitioner/Hospital b) State where a Medical Officer of the Company can visit. The injured person, if necessary.	
5. DISABILITY a) Nature of disablement b) Extent of disablement c) confined to bed/Confined to House d) Date from which can attention to normal duties e) Present state of incapacity	
6. a) Has the injured / deceased person made any claim or Received compensation under any policies or accident or Sickness in the past ? If so, give details b) State whether the injured / deceased person holds any other accident policy, If so, the name (s) of the insurers	

I hereby declare that time the particulars furnished above are true and correct to the best of my knowledge.

Date : _____

Place : _____

INSURED'S SINGNATURE

CERTIFICATE TO BE FILLED AND SIGNED BY AN EYE WITNESS TO THE ACCIDENT

I hereby certify that / I was present when the accident occurred to Mr. _____ on the ____ day of _____ 200 in the manner sated by him overleaf, that it was caused by _____ Which was / was not his willful act and that he was / was not under the influence of intoxicating liquor at that time.

Signature _____

Address _____

Occupation _____

Date _____

MEDICAL CERTIFICATE

Claims must be supported by Medical Evidence furnished the insured and at his expense.

1. a) Name of claimant b) Age	
2. a) Nature and cause of accident b) Full description of injuries / disablement c) Whether the appearance of the injuries are consistent with the account given to the accident	
3. Date on which you first attended claimant for this injury	
4. Has claimant been totally prevented from attending to normal duties? If so, how long ?	
5. Is claimant suffering form any disease of illness apart from his injury and is there any illness or circumstances which may tend retard recovery? If So, give particulars	
6. Present condition	
7. Is disablement permanent ? If so, what is percentage of disability ?	

Having personally examined the above named insured I certify that the above statement are correct and that the injured person is necessarily disabled by the accident referred to

Place : _____

Signature : _____

Name and qualification : _____

Registration No. : _____

Address : _____

Date : _____