NEW INDIA ASSURANCE

(Incorporated in India)
Registered Head Office: New India Assurance Building, 87 Mahatma Gandhi Road, Fort, Bombay-400 023, India.

PERSONAL ACCIDENT INSURANCE CLAIM FORM
(PARETICULARS OF ACCIDENT)

Policy No._____
Branch/Unit _____
Claim No._____

The Issue of this form is not to be taken as an admission of liability

TO BE COMPLETED BY THE INSURED

1. (a) Name of Insured (in full) _____
(b) Name of the injured Person (For Group Policy only) _____
(c) Address in full _____
(d) Profession or occupation _____ (e) Age last birthday _____

2.	Policy No.	Sum Insured	Table of Cover	Period
	(i)			
	(ii)			
	(iii)			

3. (a) Date of the accident (b) Time of the accident (c) Where it happened (d) Name and address of the witness	
4. How did the accident occur?	
5. Nature of injury receive (If to limb or eye state whether right or left)	
6. (a) Nature of disablement (b) Extent of disablement Confined to house Partial disablement (c) Present State of incapacity	 (From…….To…….) (From…….To…….)
7. Name and address of surgeon in attendance	
8. (a) Where and when can a Medical officer of the Company visit you, if necessary? (b) Name of nearest railway station and distance therefrom.	
9. (a) Are you insured in any other office or offices granting compensation for accident? (b) If so state name and address of company or companies and amount of insurance.	

I hereby declare that the foregoing statements are made by myself and are true in all respect and that I have not attempted to conceal from the Company anything with which it ought to be made acquainted and also that I have not abstained from any usual occupation longer than absolutely necessary and I agree that if I have made, or in further declaration the company may require, shall make any false or, fraudulent statement or any suppression, concealement or untrue averment whatever, the Policy shall be avoided and my right to compensation forfeited, and I am willing, if required to make a Statutory Declaration before a Justice of the Peace of the truth of the whole of the foregoing statement or any other statement I may make in connection with this claim.

Witness:- Name _____
Signature _____
Date _____
Address _____

Signature of the Insured _____
Date _____

CERTIFICATE TO FILLED UP 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 _____ 20_____ in the manner stated by him overleaf, that it was caused by_____ _____ which was not his willful act and that he was not under the influence of intoxicating liquor at the time.

Signature _____
Address _____
Occupation _____

* Strike out

which is not applicable

Date _____

MEDICAL CERTIFICATE

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

1. (a) Name of Claimant (b) Age

2. (a) Nature and cause of Accident

   (b) If to eye or limb state left or right

   (c) Whether the appearance of the Injuries are

   consistent with the account given of the accident

3. Date on which you first attended Claimant for this injury

4. Has Claimant been totally prevented from attending to

   any portion of his business? If so, how long.

5. Is Claimant suffering from any illness apart from his

   injury, and is there any illness or circumstances which

   may tend to retard recovery? If so, give particulars.

6. Present condition

7. How long from the happening of the Accident do you consider

   (a) Total disablement will last?

   (b) Partial disablement will last?

Having personally examined the above named Insured I Certify that the above statements are correct and that the injured Person is necessarily disabled by the Accident referred to.

Signature _____

Name and Qualifications _____

Address_____

Date______________________________ ____