The issue of this form is not to be taken as an admission of Liability

Personal Accident Insurance Claim Form (Particulars) of Accident/Death

Policy No:-_____
Principal Organisation/Department:-_____
Claim No:- _____

TO BE COMPLETED BY THE INSURED

1. (a) Name of the Employer:-_____

   (b) Name of the injured/Death Person:-_____
   (c) Address in full:-_____
   (d) Profession or Occupation:-_____
   (e) Age at the time of Death/Accident:-_____

2.

Policy No.	Name of the Claimant	Grade	Designation	Sum insured	Table of Cover	Period	Place of work

3.	(a) Date of the accident /death (b) Time of accident/death (c) Where it happened (d) Name and address of witness	
4.	How did the accident & death occur	
5.	Nature of injury received (if to limb or eye state whether right or left)	

6.	(a) Nature of disablement (b) Extent of disablement Confined to bed Confined to house (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	
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/we hereby declare that the foregoing statement are made by myself/us and are true in all respect and that I/we have not attempted to conceal from the Company anything which it ought to be made acquainted and also that I/we have not abstained from any usual occupation longer than absolutely necessary and I/we agree that if I/we have made, or in any further declaration the Company may require, shall make any false or fraudulent statement or any suppression, concealment or untrue averment whatever, the policy shall be void and my/our right to compensation forfeited and am/we 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/we may a make a connection with this claim.

Witness:-_____

Name & Signature:-_____ Signature of the principal Organization

Address:-_____ Claim Committee

Date:-……..

Note: - ***Please enclose Accident /Death certificate from the Employer /Hospital & I /Card copy of the De cease with this form***