F. No. AC – 39

Personal Accident Insurance Claim Form

Policy No. :_____

Branch/Unit :_____

Claim No. :_____

The New India Assurance Company Limited

Regd. & Head Office, 87, Mahatma Gandhi Road, Fort, Mumbai - 400 001.

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 the insured [in full] :_____

   (b) Name of the injured Person :_____

   (c) Address in full :_____

   with Pin Code : _____

   (d) Profession or occupation :_____

   (e) Age at last birthday :_____Phone No:_____

2. | | Policy No. | Sum Insured | Table of Cover | Period |
   |---|---|---|---|---|
   | [I] | | | | |
   | [ii] | | | | |

3. (a) Date of the accident :_____

   (b) Time of accident :_____

   (c) Where it happened? :_____

   (d) Name and address of witness :_____

4. How did the accident 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 [From_____To_____]

   Confined to house {From_____To_____]

   (c) present state of incapacity :_____

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 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 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 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.

Signature of the Insured_____ **DATE:** _____ **PLACE**_____

or **Signature of Nominee (in case of death of Insured) which ever is applicable**

Address: _____

_____

_____

Signature of Company Officials (with seal of Company)

DATE: _____ **PLACE:**

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

I hereby certify that I was present when the Accident occurred to Mr./ Ms._____ on the _____ day of _____200__ in the manner stated by him over leaf, 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 the time.

Signature : _____

Name : _____

Address : _____

_____**PIN CODE:**_____

Occupation : _____

Date : _____

MEDICAL CERTIFICATE

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

1. (a) Name of Claimant :_____

(b) Sex _____ (c) 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 ? : From_____To_____ With Fitness Date_____
5. Is Claimant suffering from any disease or illness apart from his injury and is there any illness by 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 Total 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 of Doctor :_____

Name & Qualification :_____

Registration No. with seal :_____

Address : _____

DATE:_____ _____

REMARKS OR EXTRA DETAILS

ECS DETAILS OF THE INSURED

1	Name of the Insured (as appearing in the Bank Account)	
2	Bank Name	
3	Branch & Address	
4	Bank Account No:	
		PIN CODE:
5	Bank Account Type	
6	IFSC Code	
7	MICR Code	

Also attach Insured name printed cancelled cheque / top sheet of pass book with the above details.