

PERSONAL ACCIDENT CLAIM FORM

PRIVATE & CONFIDENTIAL



दि ओरिएन्टल इन्श्योरेन्स कंपनी लिमिटेड
THE ORIENTAL INSURANCE CO. LTD.

Incorporated in India, Subsidiary of General Insurance Corporation of India
 Regd. Office : Oriental House, A-25/27, Asaf Ali Road, New Delhi-110 002.

This form is issued will not admission of liability, and must be completed and returned within seven days after its receipt. No claim can be admittted unless a medical Certificate overleaf be furnished a the expenses of the claimant.

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| पॉलिसी सं. Policy No. _____ | | दावा सं. Claim No. _____ | |
| 1. पुरा नाम Name in full _____ धर का पता Residence _____ उद्योग का पता Busines Address _____ Present Business or Occupation _____ If more than one, state all. | | Present Age _____ Years Height _____ M. Cms. Weight _____ at _____ Kgs. | |
| 2. (a) When did accident occur ? State day, date and hour. (b) Where did it occur ? (c) Give full particulars of the cause and the injuries sustained. | | | |
| 3. Give name and address of the Witnesses of the accident. | | | |
| 4. (a) Give name and address of the Doctor who attended you (b) Name and address of usual Medical attendant. | | | |
| 5. State where and when a Medical or other officer of the company can visit you if necessary. | | | |
| 6. (a) State the number of days have been necessarily and entirly conlined to Bed Room or House as the sole and direct result of the injuries sustained and disabled from engaging in any employment or occupation if any description whatsoever. (b) Have you in any way attended to business or work during the above period ? (c) If you have been able to attend to any portion of your business or occupation please state from what date ? | | TO BED OR ROOM for _____ days from _____ to _____ (Both inclusive) | |
| 7. Have you previously claimed or received compensation under an accident and/or sickness policy ? If so, please give particulars. | | | |
| 8. (a) Are you insured elsewhere ? (b) If so give the name of each Company or insurer and amount you are entitled to claim | | (a) _____ (b) _____ | |

I HEREBY DECLARE that I have received the injuries above described, and warrant the truth of the foregoing particulars in every respect and I agree that if I have made, or if shall make false or under statement, suppression or concealment my right to compensation shall be absolutely forfeited.

I Claim to be paid sum of _____ per week of the total sum of _____ which I agree to accept in full settlement of my claim on the Company.

दिनांक
Date _____ 200

सही
Signature _____



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टिप्पणी : यह प्रपत्र दावेदार का चिकित्सा करने वाले इलाज करनेवाले चिकित्सक के द्वारा भरे जानी चाहिए जहाँ तक संभव हो उनके जवाब पूर्ण भरे होने चाहिए.

NOTE : This form is to be completed by the Claimant's Medical Attendant whose replies should be as full as possible.

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|---|--|--|--|
| पॉलिसी नं. Policy No. _____ | | दावा नं. Claim No. _____ | |
| 1. दावेदार का पूरा नाम CLAIMANT Name in full _____ | | उम्र Age _____ | |
| 2. The nature and extent of injuries : (I to a limb state whether right or left) | | | |
| 3. The cause of the accident; so far as known to you | | | |
| 4. (a) Date of your first attendance upon him in consequence of the injuries sustained. (b) Are you still in attendance ? | | (a) (b) | |
| 5. Are you his usual Medical Attendant and if so how long have you known him and for what have you attended him ? | | | |
| 6. (a) Are his symptoms (1) due exclusively to the accident or (ii) traceable to disease, infirmity or any other cause? (b) Has he ever suffered from Govt. Rheumatism, Diabetes or Fits ? (c) Is there anything in his medical history which may have contributed directly or indirectly, to the accident or which may be likely to retard his recovery ? (d) Have you any reason to suppose that he was under the influence of intoxicants at the time of the accident ? | | (a) (i) (ii) (b) (c) (d) | |
| 7. State the time within your own knowledge, that the claimant has been, as the direct and sole consequence of the injuries sustained necessary confined to his bed room or house and disabled from engaging in any employment or occupation if any description whatsoever if still so confined state the probable duration of confinement. | | TO BED OR ROOM from _____ to _____ (Both inclusive) | |
| 8. (a) Has he been able to attend any portion of his business or occupation. (b) If so from what date (c) If not, please state probable date (i) of his being so able (ii) of his complete recovery | | (a) (b) (c) (i) (ii) | |
| 9. Is there now any disability ? If not please give date of recovery. | | | |
| 10: Any further remarks. | | | |

I hereby certify that the above named met with the accident referred to and that foregoing statement are correct.

दिनांक Signature _____ शिक्षण Qualification _____

पता Address _____ दिनांक Date _____