Claim Form

Smart Individual Personal Accident Policy

Policy No		Claim No.	
		Date of registration	
Branch Office Code			
Name & Code of Intermediary			

1. Name of the Insured	
2. Customer ID	
3. Address of the Insured	
4. Profession or Occupation	

Policy details	
Sum Insured	
Cover	

Details of Accident

5. a) Name of the insured person died/ injured in the accident b) Relationship with the Insured Policy Holder	Self/Spouse/Children

6. a) Date of the Accident b) Time of the Accident c) Where it happened? d) Name & Address of the Witness	

7. How did the Accident occur?	

8. Nature of Injury received (if to limb or Eye state whether right or left)	
9. a) Nature of disablement b) Extent of disablement c) Period of temporary total disablement d) Present state of incapacity	(From……to…..……)
10. Name and address of Surgeon in attendance	
11. Where and when can a Medical Officer of ~~our~~ Company visit you, if necessary?	
12. 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 true in all respects and that I have not attempted to conceal from the Company anything with which it ought to be made acquainted and also 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 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 We may make in connection with this claim.

Witness:

Name……

Signature ……

Signature of the Insured

Date ……..

Address ……. Date

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. …….. on the …… day of …… 20……, in the manner stated by him overleaf; that it was caused by ……*which was/was not his wilful act and that* he was / was not under the influence of intoxicating liquor at that time.

Signature ……

Address ……..

……..

Occupation ……

Date ……..

MEDICAL CERTIFICATE

(Claim must be supported by the Medical Evidence furnished by the Insured/Insured Person at his/her expense)

Name of Claimant_____Age_____

1. Nature and cause of Accident
2. If to eye or limb, state left or right.
3. Whether the appearance of the injuries are consistent with the account given of the accident.
4. Date on which you first attended claimant for this injury.
5. Has claimant been totally prevented from attending to any portion of his/her business/occupation/normal duties? If so for how long?
6. 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.
7. Present condition of the patient
8. 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:

Qualification:

Address: