युनाईटेड इंडिया इन्सुरेन्स कं. लि.
UNITED INDIA INSURANCE CO. LTD.

Regd. & Head Office : 24, Whites Road, Chennai - 600 014

DIVISIONAL/BRANCH OFFICE.....

PERSONAL ACCIDENT INSURANCE CLAIMANT'S STATEMENT

(This issue of this form does not constitute admission of liability. Please return this form duly Completed together with Death Certificate from the Hospital or the Medical Attendant, Post Mortem Certificate, if any and Police Panchanama if any)

Claim No Policy No.

1.	(a) Name of Claimant (in full) (if more than one, state names of all)	a)
	(b) Address	b)
	(c) Relationship of Claimant with the deceased	c)
2.	State nature of title under which Claimant is claiming the amount	
	Particulars of the Insured Person who died in the accident	
3.	(a) Name (in full)	a)
	(b) Last Address	b)
	(c) Occupation	c)
	(d) Age at the time of the accident	d)
4.	(a) When did the accident happen? Give date and exact time)	a)
	(b) Where did the accident happen?	b)
	(c) Give full description of the accident, its cause and Injuries sustained	c)
	(d) State date time and place of death	d)
5.	On what date did the claimant receive information in regard to the accident and from whom?	
6.	Give the name and address of two persons who witnessed the accident	
7.	(a) Was the decessed free from infirmity at the time of accident? If not, give particulars	a)
	(b) Was the deceased under the influance of drugs or drink at the time of accident?	b)
	(c) Is the Claimant satisfied that the death was directly due to the accident?	c)
	(d) Give the names and addresses of	
	(i) The Hospital, Clinic or Nursing Home where the deceased was treated afer the accident	(i)
	(ii) The Physician / Surgeon who attended on the deceased after the accident	(ii)
	(iii) His regular Physician, if any	(iii)
8.	Did the deceased have any other Accident Insurance on his life ? If so, state the name of the Insurer/s and amount/s claimed	

I/We hereby affirm and declare that the answers to all the above questions are full and true in every respect

Place :

Date:

Witnesses:

1. Signature .....

   Name .....

   Address .....

2. Signature .....

   Name .....

   Address .....

Signature of Claimant

93 - 50 x 100 I. P. 12/04

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DIVISIONAL / BRANCH OFFICE.....

PERSONAL ACCIDENT INSURANCE CLAIM FORM.

[For Disablement Claims only]

The issue of this form does not constitute admission of liability. Please return the form duly completed within Fourteen days of the accident together with the relevant prescriptions, bills, receipts etc.

Note : The words " Injured person" may be read as " Insured" if the insured and the injured person are one and the same.

	Claim No.	Policy No.
1.	INSURED	
	a. Name	a.
	b. Address	b.
	c. Phone No.	
2.	INJURED PERSON	
	a. Name	a.
	b. Address	b.
	c. Occupation [if more than one state all]	c.
	d. Age next birthday	d. Years
	e. Height	e. Cms.
	f. Weight	f. Kgs.
3	a. When did the accident happen? [Please state date and exact time]	a.
	b Where did the accident happen	b
	c. Give full descripption of the accident its cause and injuries sustained	c.
	d. Was the injured person under the influence of drugs or drinks at the time of the accident?	d.
	e. Give the names and addresses of Witnesses if any to the accident	e.

P.T.O.

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4.	a.	Give details of medical attention given and the name and address of the Medical Attendant.	a.		
	b.	If the Medical Attendant named above is not the injured person's usual Medical Attendant, give the name and address of his usual Medical Attendant.	b.		
	c.	Has he or any other Medical Attendant treated the injured person previously for any illness or injury?	c.		
	d.	State where a Medical Officer of the Company can visit the injured person, if necessary	d.		
5.		Sate the period during which injured person has been			
	a.	Confined to bed / house and unable to attend to his normal duties , at all	a.	From	To
	b.	Partially able to attend his normal duties, Whether confined to house/ bed or not	b.	From	To
6.		State date on which the injured person has been/ will be able to resume normal duties			
7.	a.	Has the injured person made any claim or received compensation under any policies of Accident or sickness in the Past? If so, give particulars.	a.		
	b.	Sate whether the injured person holds any other Accident Policy. If so, give the name (s) of the insure (s)	b.		

I / We hereby declare that the person a named above has injuries described above and that the foregoing particulars are true in every respect.

Signature of insured

Place :

Date :

Signature of injured person

MICS 108 [a]

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