PARSONAL 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 addmitted unless a medical Certificate overleaf be fornished a the expenses of the claimant.

	ज्मी सं. icy No		दावा Clai		No.	
	enA				Present A	-
1.	पुरा नाम Name in full धर का पता Residence				Height he hatte and extent of injuries	Year Heigl
	उद्योग का पता Busines Address Present Business or Occupation If more than one, state all.				nwonsize totoo thebicon tr <u>itoor</u> at K	igl
2.	 (a) When did accident accur ? State day, date and hour. (b) Where did it occur ? (c) Give full particualrs of the cause and the injuries sustained. 			(a) (d)	 (a) Cate of your first attendance upon him in consequence of the injuries substained (b) Are you still in attendance 3 	
3.	Give name and address of the Winesses of the accident.				Act you his usual Medical Altendant and if so how tong have you known him and for	
4.	 (a) Give name and address of the Doctor who attended you (b) Name and address of usual Medical attendent. 		(1) ((a)	whethave you the identifient? (a) Are the symptoms (1) due exclusively to the accident or (ii) fraceable to disease; intimity or any other cause? (b) they fraceaor sufficient from Gord	
5.	State where and when a Medical or other officer of the company can visit you if necessary.			(0) (0)	Rhoumatism. Diobetes or Fils ? (c) is there anything in his medical history which may have contributed	
6.	(a) State the number of days have been necessarily and entirly conlined to		BED OR ROOM		diffecting of indiffecting to the secondent of one of the secondent of the	
	Bed Room or House as the sole and direct result of the injuries sustained	for		day	(d) Have you any reason to suppose the country was under the influence col- context at the time of the acceleration	
	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 ?	MOON	(Both inclusive)		State the time within your own know edge, that the clamant has been, as the clamat	
		(evia	(Both inclusion)	<u>conf</u> _ 63	and sole consequence of the infinites sustained necessary controled to his bed poin or bouse and dissoled from engaging in any amployment or occupation if any	
	(c) If you have been able to attend to any portion of your business or occupation please state from what date ?	(c)				
7.	Have you prevously claimed or received compensation under an accident and/or sickness policy ? If so, please give particulars.			(d) (c) (j)	of his busines of occupation (b) if so from what date (c) if nots please state probable date (i) of his being so able	
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) ·			(iii) any any disability 7 it not please over date of repovery Any locher reinarks	19

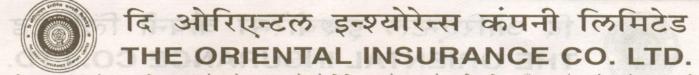
every respect and I agree that if I have made, or if shall make false or under statement, supperssion or concealment my right to compensation shall be absolutely forefeited.

I Claim to be paid sum of	per week of the total sum of		
which I agree to accept in full settleme	ent of my claim on the Company.		
दिनांक		सही	

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D	a	te	

Signature _

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

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

पॉलिसी स.				दावा स.		
Policy No			Claim No.			
	विदर का पुरा नाम			उम्र		
. C	LAIMANT Name in full			Age	_	
	he nature and extent of injuries : to a limb state whether right or left)			eonsbiade III Residence		
3. The cause of the accident; so far as known to you		stant 19 ng Busines Address Prepart Business or Occupation It more than one, state all				
	 a) Date of your first attendance upon him in consequence of the injuries substained. b) Are you still in attendance ? 	(a) (b)	×	 E.d. When did anomation accur? State day dute and hom. (b) Where did x accur? (b) Where did x accur? (c) (\$ve full periodeles of the cause and the opmers sustented. 		
S	re you his usual Medical Attendant and if b how long have you known him and for hat have you attended him ?			Give name and address of the Winesses of the accident		
б. (а		(a) ((b))	 In Namo and address of deust Medical In Namo and address of deust Medical 		
(0		(c)		State where and when a Werkcal er other others of the company cart work you if necessary		
 or which may be likely to returd his recovery? (d) Have you any reason to suppose that he was under the influence of intoxicants at the time of the accident? 		10 85D OR ROOM				
. S	tate the time within your own knowledge,		TO BED OR ROOM	Aue of Suidebus wort peringsp pour	-	
	at the claimant has been, as the direct		(eviaulor) dieB)	description whatsover		
su rc in de	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	(Both inclusive)	 (b) Have you in any way allended to the business or work during the doore 		
) Has he been able to attend any portion	(a)		pages state from what date ?	-	
	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	(b) (c) (i) (ii)		Have you prevously claimed or roceived componsation under an accident and/or sickness policy ? If so, please give particulars		
	there now any disability ? If not please ve date of recovery.			 (b) It so give the name of cash Company or never and encoded you are entitled 		
: Any	further remarks.					
er Aur	y certify that the above named met w Signature	915 1001		that foregoing statement are correct.	H DN DI	
T Ad	dress			alifitio de bale som of		
1	88 ARO U.T. 200 x 100 11/99					