PARSONAL ACCIDENT CLAIM FORM

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.

पॉलिसी सं. Policy No. ______	दावा सं. Claim No. ______

1.	पूरा नाम Name in full ______ घर 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 accur ? State day, date and hour. (b) Where did it occur ? (c) Give full particualrs of the cause and the injuries sustained.	
3.	Give name and address of the Winesses of the accident.	
4.	(a) Give name and address of the Doctor who attended you (b) Name and address of usual Medical attendent.	
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.	TO BED OR ROOM for ______ days from ______ to ______ (Both inclusive)
	(b) Have you in any way attended to business or work during the above period ?	(b)
	(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.	
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, 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 settlement of my claim on the Company.

दिनांक
Date ______ 200

सही
Signature ______

PRIVATE & CONFIDENTIAL **MEDICAL REPORT**

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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 सं. Policy No.	दावा सं. Claim No.
दावेदर का पुरा नाम 1. 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 substained. (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 returd 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 ______

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