नेशनल इन्श्योरेन्स कंम्पनी लिमिटेड
NATIONAL INSURANCE COMPANY LIMITED

Address for Communication :
National Insurance Co. Ltd
Bombay Division X/251000

CLAIM FORM
Personal Accident

(The completed claim form should be returned to the policy Issuing Office of the Company within 7 days. The Company does not admit liability by issuing this form)

Policy No : 251000/

Claim No. :

The Claim Form is to be completed by the Insured. If the Insured is unable to complete the Form it may be filled up on his behalf. In case of Group personal Accident Policy the information asked for should relate to injured person covered under the policy.

1) Name of Insured (in full) _____

2) Name of the Injured Person (in case of Group PA policy) _____

3) Age of the Insured/Injured Person (last birthday) _____

4) Address in full _____

_____

5) Profession or Occupation of the Insured/Injured Person _____

6) State the following

(a) Date of Accident
(b) Time of Accident
(c) Where it Happened ..AM/PM

7) State how did the accident occur ..

8) State as fully as you can the nature and extent of the injuries sustained

9) Give the name and address of the Doctor/Hospital/ Nursing Home where the Insured/Injured Person is being treated for these injuries.

Has any other Medical man been consulted ? ...Yes/No.

10) When and where can the Insured or the injured person be visited if necessary by a Medical Officer or an Official of the Company ?

11) Was the Insured/Life Insured in good health and free from physical defact or infirmity at the time of the accident ?

12) Is a claim being made under any other Personal Accident Insurance ? If so, please state name and address of the Insurance Company alongwith its Policy Number.

DECLARATION

I hereby declare that the foregoing statements are made by myself and 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 I agree that if I have made or in any further declaration the Company may require, shall make any false or fraudulent statment or any suppression, concealment or untrue averment whatever, the Policy shall be void and my right to compensation forfeited and I 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 I may make in connection with this claim.

Witness ;

Signature of Insured_____
or Injured Person

Signature_____

Date : _____

Name : _____

Address_____

_____

_____

_____

For Office use Only
Claim No :
Policy No :

MEDICAL CERTIFICATE
(ATTENDING DOCTOR'S REPORT)

1) Name and Age of Injured Person :

Address

2. Describe Nature and extent of injuries :

3. Cause of the accident so far as it is known to you :

4. (a) When did you firs t end on the injured Person following the accident ? :

(b) Are you still attending on him ? :

5 Are you his usual medical Attendant ? If you have treated him for any previous illness or injury, please give details

6. (a) Are his injuries
(i) solely due to the accident or
(ii) traceable to any disease infirmity, previous injuries or any other cause ? :

(b) Is the injured Person suffering from any disease or injury (apart from this injury) which directly or indirectly

(i) may have contributed to the accident, or

(ii) is likely to retard his recovery from the injuries or

(iii) Is likely to aggravate his conditions ? :

(c) Was he to your knowledge under the influence of intoxicants or drugs at the time of accident ?

7. (a) According to you how long has the Injured Person to be confined to bed/house as the direct and sole consequence of the injuries sustained ? :

(b) During this period will the Injured Person be able to attend to any portion of his normal duties ? If so from what date ?

(c) If not please state probable date of
(I) His being able to attend to any portion of his normal duties.
(ii) His resumption of his normal duties fully.

8. Any other remarks you wish to make

I hereby certify that injuries sustained by the Person mentioned above are in accordance with the nature of the accident as described to me and that I treated him for the said injuries

Doctor's Name Regn. No. Qualification

Address

Docror's Signature

Date

Note : The fee, if any, for this Report will be borne by the Injured Person.

Forwarded to

NATIONAL INSURANCE COMPANY LIMITED
Bombay Division X 251000,
Resham Bhavan, 6th Floor,
78, Veer Nariman Road, Bombay-400 020