PERSONAL ACCIDENT CLAIM FORM

The Oriental Insurance Company Limited

Registered Office: "ORIENTAL HOUSE", A-25/27, Asaf Ali Road, New Delhi-110002

This form is issued without admission of liability and must be completed and submitted to the Insurer. No claim can be admitted unless a **Medical Report** overleaf be furnished at the expense of the claimant.

Claim No. _____ Policy No._____
(To be filled by the Insurer)

1. **INSURED'S PERSONAL DETAILS**:

a. Name in Full _____ f. Present Age _____ Years

b. Residential Address :(with PIN code)_____ g. Height _____

c. Office Address (with PIN code) _____ h. Weight_____

d. Contact No.: Phone with STD code:_____ Mobile no._____

e. Occupation _____

2. (a) When did the accident occur?	_____ _____ _____ _____ Day Date Month Year
(b) Where did it occur? (c) Full particulars of the cause of accident (d) Details of injuries sustained	…… …… …… …… ……
3. Give name and address of the witness of the accident	
4. (a) Give name and address of the Doctors who attended you (b) Name and address of your Ordinary Medical Attendant (c) Name & Address of Hospital/ Nursing Home where treatment taken	
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 you have been necessarily and entirely confined to bed, Room, or House as the sole and direct result of the injuries sustained (b) If still confined, state probable duration Of confinement (c) Have you in any way attended to business or work during the above period? (d) Have you been able to attend to any portion of your business or occupation and if so, from what date?	6. (a) Confined for…….days From ..... To..... (b) From…… To……. (c) ..... (d).....
7. Have you previously claimed or received compensation under an accident and/or Sickness policy? If so, please give particulars.	7. ....
8. (a) Are you Insured elsewhere? (b) If so give the name of each Company or Insurer and the 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 make false or untrue statement, suppression or concealment, my right to compensation shall be absolutely forfeited.

I claim to be paid a sum of……per week, or the total sum of…….. which I agree to accept in full settlement of my claim on the Company.

Date…… Signature.....

Name .....

MEDICAL REPORT

The Oriental Insurance Company Limited

Registered Office: "ORIENTAL HOUSE", A-25/27, Asaf Ali Road, New Delhi-110002

Note: This form is to be completed by the claimant's Medical Attendant whose replies should be as full as possible.

Policy no._____ Claim no._____

1. CLAIMANT- Name in full_____ Age_____

2. The nature and extent of injuries (if 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 sustained? (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 (i) due exclusively to the accident (ii) traceable to disease, infirmity or any other cause? (b) Has he suffered from Gout, Rheumatism, Diabetes or Fits?	(a) (i) (ii) (b)

6. (c) Is there anything in his medical history which may have contributed directly or indirectly to the accident or which may be likely to retard his recovery? (d) Have you any reason to suppose that he was under the influence of intoxicants at the time of the accident ?	(c) (d)
7(a) State the time within your knowledge that the claimant has been, as the direct and sole consequence of the injuries sustained, necessarily confined to his house. (b) If still so confined state the probable duration of confinement too.	7 (a) (b)
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	8.(a) (b) (c) (i) (ii)
9. Is there now any disability ? If not, please give date of recovery.	9.
10. Any further remarks.	10.

I hereby certify that the above named met with accident referred to and that the foregoing statements are correct

Signature_____ Qualification_____

Name: Dr._____ Regn. No. _____

Address_____ Date_____

Phone No. _____ Mobile No._____

TOTAL DISABLEMENT occurs when the insured is wholly prevented from attending to his business/occupation.

PARTIAL DISABLEMENT when prevented from attending to a sustained portion thereof.