CIN: U66010DL1947GO1007158

Mumbai City D.O: 2, 4th Floor, Oriental House, 7, J. Tata Road, Churchgate, Mumbai – 400020.

CLAIM FORM FOR ACCIDENTAL DEATH / DISABLEMENT

UNDER POLICY NUMBER: 121100/47/2023/____

Aadhar Number: ..... Rice Card No: ....., Portal Claim ID: .....

OICL Claim No: ..... District: ..... Other Reference: .....

S. NO	DESCRIPTION	DETAILS	
Section I: (To be completed in respect of all claims)			
1	Name of the Insured		
2	Address of the Insured		
3	Date of Birth/ Age of the Insured		
4	Occupation		
5	Date and Time of Accident		
6	Place of Accident		
7	Date of Death (if applicable)		
8	Cause and Description of Accident		
9	Reported to police or not?	(a) Yes	Details:
		(b) No	

10	Were you removed to hospital immediately after the accident?	Yes/ No. If Yes Give name and address of the Hospital:
Section – II (To be completed if answer to S. No: 10 is 'Yes') (To be completed by Hospital Authorities Only)		
11	Removed/ admitted to hospital as	In-Patient/ Out-Patient/ Emergency
12	Date of admission	
13	Date of discharge	
14	Nature of injury	
15	Particular of treatment	
16	Has the accident resulted into loss of: a) Sight of both eyes (or) b) Two entire hands (or) c) Two entire feet (or) d) Sight of one eye and one entire hand or one foot (or) e) Sight of one eye (or) f) One entire hand or one entire foot (or) g) Use of hand or a foot without physical separation which may prevent insured from engaging in or being occupied with or giving attention to any employment or occupation whatsoever?	

	If yes, please give details	
17	Submit the following documents	a) Medical practitioner's certificate **or** Dispensary Notes and certificate showing reasons of becoming handicapped or non-functioning or organ **(or)** b) Certificate of Primary Health Care Centre/ Sub District Health Official, with the counter signature of District Civil Surgeon.
18	Signature of Competent Authority of Hospital/ Nursing Home	…….. Date:…… Designation:…….. Stamp: Signature of Insured. :

Section: III (To be completed by nominee in the event of insured's death)		
	Details of Nominee:	
19	Full Name of Nominee	
20	Address of Nominee	
21	Age of Nominee	
22	Relationship of Nominee with deceased	
23	Signature of Nominee	
24	Please attach all the requisite documents as per MoA/ SoP	

Declaration: To be signed by the insured (in case of disability claim) or by the Nominee (in the event of the death of the insured):

I/ HEREBY DECLARE and warrant that the truth of the above particulars in every respect. I have not concealed or suppressed any facts and agree that if I have made or shall make false or untrue statement or conceal any material information, my rights for compensation shall be forfeited.

I ALSO HEREBY DECLARE that I am accepting the amount of Rs. _____/- in full discharge of your obligations under the policy to the insured and/or his/her legal heirs and I will hold you indemnified in the event of any claims under this policy being made against you by any other person or persons.

Signature:

Date:

Place: