



**UNITED INDIA INSURANCE COMPANY LIMITED**

REGD & HEAD OFFICE: NO 24 WHITES ROAD CHENNAI – 600 014

*The issue to this form is not to be taken as an admission of Liability*

**Personal Accident Insurance Claim Form (Particulars) of Accident**

Policy No. \_\_\_\_\_

Claim No. \_\_\_\_\_

---

**TO BE COMPLETED BY THE INSURED**

---

1. (a) Name of the Insured [in full] \_\_\_\_\_  
(b) Name of the injured Person \_\_\_\_\_  
(c) Address in full \_\_\_\_\_  
(d) Profession or occupation \_\_\_\_\_  
(e) Age at last birthday \_\_\_\_\_

- 2.
- | Policy No. | Sum Insured | Table of Cover | Period |
|------------|-------------|----------------|--------|
| (i)        |             |                |        |
| (ii)       |             |                |        |
| (iii)      |             |                |        |

3	a) Date of the accident? Time of accident? Place of Accident? Name and address of witness	
4	How did the accident occur ?	

5.	Nature of injury received (If to limb or eye state whether right or left)	
6.	a) Nature of disablement Extent of disablement Confined to bed Confined to house b) Present state of incapacity	[ from _____ To _____ [ from _____ To _____ ]
7.	Name and address of surgeon in attendance	
8.	a) Where and when can a Medical Officer of the Company visit you, if necessary ? Name of nearest railway station and distance therefrom	
9.	α) Are you insured in any other office or offices granting compensation for accident If so state name and address of company or companies and amount of insurance	

I hereby declare that the foregoing statements are made by myself and are true in all respect and that I have not attempted to conceal from the Company anything which it ought to be made acquainted and also that I have not abstained from any usual occupation longer than absolutely necessary and I agree that if I have made, or in any further declaration the Company may require, shall make any false or fraudulent statement or any suppression, concealment or untrue averment whatever, the Policy shall be void and my right to compensation forfeited and 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 a connection with this claim.

Witness:

Name \_\_\_\_\_

Signature of the Insured \_\_\_\_\_

Signature

Date :

Date

Address

**CERTIFIED TO BE FILLED UP AND SIGNED BY AN EYE WITNESS TO THE ACCIDENT**

I hereby certify that I was present when the Accident occurred to  
Mr. \_\_\_\_\_ On the \_\_\_\_\_ day of  
\_\_\_\_\_ 20 \_\_\_\_ in the manner stated by him over leaf, that it was  
caused by \_\_\_\_\_ which \* was / was not his willful act and that he \*  
was/was not under the influence of intoxicating liquor at the time

Signature

\_\_\_\_\_

Address \_\_\_\_\_

\* Strike out which is not applicable Occupation \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_

**SECTION II (TO BE FILLED IN BY HOSPITAL AUTHORITIES)**

1. Name and address of the hospital:-----

2. Date of admission: -----

3. Date of discharge:-----

4. (a) nature of injury:-----

(b) Particulars of treatment:-----

5. Has the accident resulted into loss of hand/s or foot/feet or eye/s permanent disability of any other type which may prevent the insured from engaging in or being occupied with or giving attention to any employment or occupation whatsoever. If yes, please give details-----

6. Hospital expenses (Please attach original bills)-----

Date:

Signature of the Competent Authority  
of Hospital / Nursing Home

Designation -----

**Section III (To Be Completed By Nominee In The Event OF Insured's Death)**

Details of Nominee

(a) Full Name:-----

(b) Address:-----

(c) Age:-----

(d) Relationship with deceased:-----

Date:-----

-----  
Signature of nominee

Please attach the following documents:

- 1. Original Death Certificate
- 2. FIR & Post Mortem Report
- 3. Legal heir Certificate

**Declaration to be signed by the insured / claimant or by the nominee (in the event of insured's death)**

I/We hereby declare and warrant the truth of the foregoing particulars in every respect. I/We agree that if I/We have made, or if, shall make false or untrue statement, suppression or concealment, my/our right to compensation shall be forfeited.

I/We also here declare that I am / We are accepting the amount in full discharge of your obligation under the policy to the insured and/or his/her legal heirs and I/we will hold you indemnified in the event of any claim under this policy being made against you by any other person or persons.

Date:-----

Signature-----