CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED
Registered and Head Office: "Dare House", II floor, Old No.234, New No.2, NSC Bose Road, Chennai - 600 001. India

Cholamandalam MS
GENERAL INSURANCE

Personal Accident – Claim Form

(The issuance of this form does not imply admission of liability.)

CLAIM NO: _____ **POLICY NO:** _____

INSURED'S DETAILS	
1. Name of the Insured	
2. Address of communication	
3. Name of person met with the accident – (Injured Person) (IP)	
4. Relation with the Insured	
5. Date of birth of the IP	
ACCIDENT DETAILS	
6. Date & time of accident	
7. Place of accident	
8. Brief description of accident	
9. Nature of injury	
10. Name & Address of the Hospital/Nursing home/Doctor where the injured person is treated.	
11. Has the Police been informed about the accident If yes please give details	1. FIR No. 2. Name & Address of Police station
12. Was the Injured Person under the influence of liquor/drugs at the time of accident.	Yes ☐ No ☐
13. Witnesses of accident Name and contact details incl. Phone No.	1. 2.
14. Where the Injured person can be contacted	

15. Disability Type & Period A. Permanent Total Disablement: Nature Percentage B. Permanent Partial Disablement: Nature Percentage C. Accidental weekly indemnity: No. of days: Date of accident: Date of fitness: Attach Dr. certificate) Date of resuming duties: D. DEATH Details of the nominee –Name & Address :	
16. Any other benefit opted under the policy A. B. C.	

I/We hereby to the best of my/our knowledge and belief, warrant the truth of the above details in every respect. I/We agree that if we have made already or if I/We make in any of my/our further statements in respect of the said incident any false or fraudulent declarations or suppress or conceal any material fact, the Policy shall be void and all rights of compensation in respect of the present or future accident shall be forfeited

Place:

Date :

Signature of Claimant/Insured