IFFICO-TOKIO GENERAL INSURANCE CO. LTD.

Regd. Office : 34, Nejru Place, New Delhi - 110 019

Surat Office : 1st Floor, House - A, 21st Century Business Center, Nr. World Trade Center, Ring Road, Surat. Ph. : 2366145, 2337217

Claim No. : ________ Date of Issue : ____________

INDIVIDUAL PERSONAL ACCIDENT INSURANCE CLAIM FORMS

- Please note that this Claim Form is issued with out prejudice to the terms and conditions of the Policy and issuance of this form should not be construed as admission of Liability.
- Please fill in all the blanks and give complete details of information asked for, In case space provided is found insufficient, a separate sheet may kindly be annexed.
- Please return this form, duly filled & signed, with in 7 days, the date of it's issuance.
- Attach copy of death Certificate/Posr Mortem Report / Police Pabchnama / Medical Certificate, whichever is applicable.

Policy / Cover No.			
Name & Address of the Injured Person (who has suffered injury / died in accident)			
Age			
Occupation			
Particulars of Claimant/(s) (to be filled inc case other than insured person)			
Sr. No.	Full Name	Address	Relationship with insured
Title under which the claimant is claiming			
Date & Mode of Receipt of Information			
Date of Accident	Time of Accident	Exact Location of Accident	
Description of Accident		Cause of Accident	
Name & Address of at least 2 Witnesses	1. 2.		
Extent of Injury			
Date & time of Death			
Name /Add of Hospital (where injured was treated)			
Name/Add of Doctor (who attended injured)			
Amount Claimed			
Details of Other Existing Insurances			
Name & Address of Company	Policy No.	Sum Insured	

I, undersigned confirm that above given details are true & correct tot the best of my knowledge.

Name : Signature : Date :

MEDICAL CERTIFICATE

Claims must be supported by medical Evidence furnished by the insured at his expense

1. (a) Name of cliamant .... (b) Age ....

2. (a)Nature and cause of Accident ....

   (b)If to eye or limb, state left or right ....

   (c)Whether the appearance of the Injuries are consistent with the account given of the accident. ....

3. Date on which you first attended Claimant for this injury..

4. Has Claimant been totally prevented from attending to nay portion of his business ? If so how long ?..

   ....

5. Is Claimant suffering from any disease illness apart ? .... From this injury and is there any illness by circumstances Which may tend to retard recovery ? If so, give particulars ....

6. Presnet condition ....

7. How long from the happening of the Accident do you consider Total disablement will last .... Temporary ?

Having personally examined the above named Insured I Certify that the above statement are correct and that the insured person is necessarily disabled by the Accident referred to.

Signature ....

Name and Qualification ....

Address ....

Date : ____________________

REMARKS