UNITED INDIA INSURANCE COMPANY LIMITED

Head Office: 24, WHITES ROAD, CHENNAI - 600014

CLAIM FORM FOR ROAD SAFETY POLICY

(JANATA PERSONAL ACCIDENT INSURANCE WITH MEDICAL EXPENSES ARISING OUT OF ROAD ACCIDENT)

Policy No. ..... Claim No.....

1. Name of insured Person: _____

2. Name of the Injured / Deceased Person: _____
   - i) Whether occupant: Y/N
   - ii) Whether Third Party: Y / N If yes, pedestrian / cyclist/ _____
   - iii) Whether Driver: Y/ N If yes, license No. _____RTO_____

3. a) Date & time of Accident: Date :_____Time:_____ a.m./p.m
   b) Place of Accident: _____
   c) Details of Accident: _____
   d) Whether intimated to Police: Y / N, Police Station _____
   e) FIR/SDE No.: No. _____Date_____

4. If Injury i) Nature of Injury: _____
   ii) Extent of Injury: _____
   iii) Medical Practitioner (Who has attended the patient): _____
      a) Name: _____
      b) Address: _____
      _____
   iv) Hospital/ Nursing Home (Where treatment is taken):_____
      a) Name
      b) Address/Phone Numbers

   V) Treatment Details
      a) Period of Treatment:
      b) Date of Admission:
      c) Date of Discharge:

   vi) SCHEDULE OF EXPENSES INCURRED BYTHE CLAIMANT

Details of Expenses claimed under Hospitalisation/Domiciliary Hospitalisation. (to be supported by Bills/Receipts , Cash Memos etc.)	Amount Claimed Rs. (1)	Amount not payable Rs. (2)	Net Payable
A) HOSPITALISATION BENEFITS: a) Room Board, Nursing Expenses For ..... days..... b) IC Unit for .....days ..... Rs.....per day. B) SURGICAL & NON-SURGICAL DISEASE: a) Surge on & Anaesthetist fees..... b) Anaesthesia, Blood, Oxygen,			

Operation Theatre, Surgical Appliances ..... c) Diagnostic Materials & X-Ray d) Medical Practitioner Consultant and Specialist fees for Consultations / visits..... e) Medicines & Drugs: a) Supplied by Hospital ..... b) Purchased from Chemists.....			

vii. In case of Disablement:
   a) Disability Factor: Enclose Disability Certificate in Original _____
   b) Certified by: _____
   c) Claimed: _____

5. In case of Deatth
   i) Post Mortem Report Date: _____
   ii) Death Certificate Date: _____
   iii) Legal heir Certificate / Date: _____
   iv) Nominee's Name: _____ Age: _____
   Relation with deceased:
   Address:
   v) Claimed Amount:_____
6. Whether any other JPA Insurance Policy is there? Yes/No If yes Sum Insured _____
   Insurance Company:

In support of the above claim, I enclose the following documents
(Please tick the documents enclosed).

1. Bill Receipt and Discharge Certificate/card from the Hospital
2. Cash Memos from the Hospital-/ Chemist (s), supported by the proper prescription.
3. Receipt and Pathological test reports from a Pathologist supported by the note from the Hospital/Medical Practitioner / Surgeon demanding such Pathological tests.
4. Surgeon's certificate stating nature of operation performed and Surgeon's Bill & receipt.
5. Attending Doctor/ Consultant/ Specialist/ Anaesthetist's bill and receipt and certificate regarding diagnosis:-
6. Certificate from the attending Medical Practitioner/ Surgeon that the Patient is fully cured.
7. Postmortem Certificate
8. Death Certificate
9. Legal heir Certificate
10. Copies of other JPA insurance policies existing at the time of accident

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance.

Dated at ..... this ..... day of .....20.....

SIGNATURE OF CLAIMANT

FOR OFFICE USE: