

# Janata Personal Accident Policy

## Claim Form



WITH YOU ALWAYS

Tata AIG General Insurance Company Limited: A-501, 5th Floor, Building No.4, Infinity Park, Gen. A.K. Vaidya Marg, Dindoshi, Malad (East), Mumbai 400 097

### IMPORTANT:

1. Issuance of this form is not an admission of Liability or a waiver of the terms, conditions and exceptions of the insurance contract.
2. No claim will be admitted without a Medical Report as per format to be obtained at claimant's expense.

Claim No.

Policy No.

### 1. PERSONAL DETAILS

Name (In block letters)

a) Insured

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
First Name	Middle Name	Surname	

b) Claimant

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
First Name	Middle Name	Surname	

Address

<input type="text"/>
----------------------

City

<input type="text"/>
----------------------

State

<input type="text"/>
----------------------

PIN

<input type="text"/>
----------------------

Phone (O)

<input type="text"/>
----------------------

(R)

<input type="text"/>
----------------------

Fax

<input type="text"/>
----------------------

Mobile

<input type="text"/>
----------------------

E-mail

<input type="text"/>
----------------------

Age

<input type="text"/>
----------------------

yrs. Current Employers

<input type="text"/>
----------------------

Occupation

<input type="text"/>
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### 2. CONTACT DETAILS

Address where available

<input type="text"/>
----------------------

Phone

<input type="text"/>
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(Please be available at this place where our representative may call on you)

### 3. DETAILS OF ACCIDENT

Time and Date

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y	Y	Y		

Place and Location  
(full address)

<input type="text"/>
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Cause Description

<input type="text"/>
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<input type="text"/>
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### 4. DETAILS OF INJURIES

Specify injured  
parts of body

<input type="text"/>
----------------------

<input type="text"/>
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Total disablement  
(if any)

<input type="text"/>
----------------------

Percentage

<input type="text"/>
----------------------

%

<input type="text"/>
----------------------

(In words)

Furnish Certificate of Disability from Competent Authorised Govt / Civil Surgeon

### 5. WITNESSES

1) Name

<input type="text"/>
----------------------

Address

<input type="text"/>
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City

<input type="text"/>
----------------------

State

<input type="text"/>
----------------------

PIN

<input type="text"/>
----------------------

Phone

<input type="text"/>
----------------------

Mobile

<input type="text"/>
----------------------

2) Name

Address

City

State  PIN

Phone  Mobile

**6. TREATMENT DETAILS**

A. Name of Casualty Doctor

Address

Phone  Registration No.

B. Name of Family Doctor

Address

Phone  Registration No.

C. Name of Hospital

Address

Phone

**7. AMOUNT OF CLAIM**

A. Accident Death Amount (Rs) \_\_\_\_\_

B. Accidental Permanent Dismemberment / Disability Amount (Rs) \_\_\_\_\_

C. Permanent Total Disability Amount (Rs) \_\_\_\_\_

**8. PAST HISTORY**

A. Did you have any past medical history / treatment in the PAST?  YES  NO

B. Have you made any claims in the PAST ?  YES  NO

C. If YES, please give details including accident and Insurance details \_\_\_\_\_

9. Are you insured under any other policy ?  YES  NO

If YES, please give full details \_\_\_\_\_

10. Have the Police Authorities been informed of this accident?  YES  NO

If YES, Case No. \_\_\_\_\_ Police Station \_\_\_\_\_

I hereby declare that I have suffered injuries as described above and all the details given are **ABSOLUTELY TRUE AND CORRECT**. I hereby agree to forfeit all my rights to compensation if any of the foregoing facts and /or details are found to be false or incorrect. I further authorise the hospital ,doctor diagnostic laboratory, organisation, establishment or any other body or person dealt with in the course of this claim to give any information or document sought for by the Insurance Company.

Date: \_\_\_\_\_

Place: \_\_\_\_\_

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



## **Tata AIG General Insurance Company Limited**

**Registered Office:** Peninsula Business Park, Tower A, 15th Floor, G. K. Marg, Lower Parel, Mumbai - 400 013.

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