ISSUING OFFICE

The Oriental Insurance Company Limited

Head Office, A-25/27, Asaf Ali Road, New Delhi-110 002

PERSONAL ACCIDENT POLICY (INDIVIDUAL)

CLAIM FORM

This form is issued without admission of liability and must be completed and returned within 7 days after its receipt. No claim can be admitted unless a medical overleaf be furnished at the expense of the claimant.

Claim No._____	Policy No._____
1. Name in Full_____ Residence_____ Business Address_____ Permanent Business or Occupation if more than one state all_____	Present Age _____Year Height_____ft._____Inc____ Wt._____st_____lbs
2. a) When did the accident occur? State day, date and hour b) Where did it occur? c) Give full particulars of the cause and the injuries sustained.	
3. Give name and address of the witness of the accident.	
4. a) Give name and address of the Doctors who attended you. b) Name and address of your ordinary Medical Attendant.	
5. State where and when a Medical or other officer of the Company can visit you, if necessary.	
6.(a) State the number of days you have been necessarily and entirely confined to Bed, Room or House as the sole and direct result of the Injuries	6. (a) confined for …day……. From ……to (b)……

sustained. (b) If still confined, state probable duration of confinement. (c) Have you in any way attended to business or work during the above period? (d) Have you been able to attend to any portion of you	(b) (c) (d)
7. Have you previously claimed or received compensation under an Accident and/or Sickness Policy? If so, give Particulars.	
8. a) Are you insured elsewhere? b) If so give the name of each Company or Insurer and the amount you are entitled to Claim.	(a) (b)

I HEREBY DECLARE that I have received the injuries above described and warrant the truth of the foregoing particulars in every respect, and I agree that if I have made, or if shall make false or untrue statement, suppression or concealment, my right to compensate shall be absolutely forfeited.

I claim to be paid sum of……..per week, or the total sum of ……which I agree to accept in full settlement of my claim on the company.

Dated_____ Signature_____

PRIVATE AND CONFIDENTIAL **MEDICAL REPORT**

The Oriental Insurance Company Limited

Head Office, A-25/27, Asaf Ali Road, New Delhi-110 002

Note: this form is to be completed by the claimant's Medical Attendant whose replies should be as full as possible.

Policy No.	Claim No.
1. CLAIMANT Name in full_____	Age_____
2. The nature and extent of injuries (if to a limb, state whether right or left)	
3. The cause of the accident, so far as known to you.	
4. a) Details of your first attendance upon him in consequence of the injuries sustained? b) Are you still in attendance	a) b)
5. Are you his usual Medical Attendant and if so, how far have you known him and for what have you attended him?	
6. a) Are his symptoms (i) due exclusively to the accident or (ii) traceable to disease, infirmity or any other cause? (b) Has he ever suffered from Gout, Rheumatism, diabetes or fits? (c) Is there anything in his medical history which may have contributed directly or indirectly to the accident or which may be likely to retard his recovery. (d)Have you any reason to suppose that he was under the influence of intoxicants at the time of accident?	(a) (i) (ii) (b) (c) (d)

7. (a) State the time within your own knowledge that the Claimant has been, as the direct and sole consequence of the injuries sustained, necessarily confined to his house. (b) If still so confined state the probable duration of confinement too.	7. (a) confined for ……..days From……(both inclusive) (b) ……
8. (a) Has he been able to attend any portion of his business or occupation? (b) If so from what date? (c) If not, please state probable date (i) Of his being so able (ii) Of his complete recovery	(a) (b) (c) i. ii.
9. Is there now any disability? If not, please give date of recovery.	
10. Any further remarks	

I hereby certify that the above named met with accident referred to and that the foregoing statement are correct.

Signature_____ Qualification_____

Address_____ Date_____

TOTAL DISABLEMENT occurs when the Insured is wholly prevented from attending to his business/occupation. PARTIAL DISABLEMENT when prevented from attending to a substantial portion thereof.