IFFCO-TOKIO GENERAL INSURANCE COMPANY LIMITED

Registered Office: 34, Nehru Place, New Delhi – 110019
501-503 & 505, 5th Floor, Iskon Atria-1, Opp.GEB Training Centre, Near Yash Complex, Gotri Road, Vadodara-390021
Phone: 0265 – 6457219/20, Fax: 0265 – 2356476

Claim No.: _____ Date of Issue: _____

GROUP / INDIVIDUAL PERSONAL ACCIDENT INSURANCE CLAIM FORM

- 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, from the date of it's issuance.
- Attach copy of Death Certificate/Post Mortem Report / Police Panchnama / Medical Certificate, whichever is applicable.

Policy No./ Sr. No. of Schedule			
Name & Address of the Insured Person (who has suffered injury / died in accident)			
Age			
Occupation			
Particulars of Claimant/(s) (to be filled in 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)			
Name/Add of his Family Doctor			
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 to the best of my knowledge.

Name & Signature with Date:

IFFCO-TOKIO GENERAL INSURANCE
Muskurate Raho

MEDICAL CERTIFICATE

Claims must be supported by medical evidence Furnished by the insured and at his expense.

1. (a) Name of claimant_____(b)Age_____

2. (a) Nature and cause of Accident_____
   (b) If to eye of 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 any portion of his business? If so, for 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? Is so, give particulars:
   _____

6. Present condition_____

7. How long from the happening of the accident do you consider Temporary total disablements will last? _____

Having personally examined the above named insured, I certify that the above statements are correct and that the insured person is necessarily disabled by the accident referred to.

Signature: _____

Name and Qualification: _____

Address: _____

_____

Date: _____

REMARKS