INDIA INTERNATIONAL INSURANCE PTE LTD

In service since 1987

Personal Accident Claim Form

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

Policy Number			
Name of Insured	Mr / Miss / Mrs / Mdm / Dr .		
Address of Insured			
Contact Number		Email	
Date of Birth			
Occupation			
Address/Place of accident			
Describe how the accident occurred			
Describe the injuries sustained			
Date of accident		Time of accident	
Has the same part been injured previously?	☐ Yes ☐ No		
Names of Witness			
Address of Witness			
Name of attending Doctor			
Address of attending Doctor			
Name of your Medical Attendant			
Address of your Medical Attendant			
Would you like a Medical or other officer of insurer to visit you?	☐ Yes ☐ No If yes, please state the date _____		
Probable period of disablement			
Have you been totally unable to attend to any part of your business?	☐ Yes ☐ No If yes, please state the date _____ to _____		
Are you still totally unable to attend to any of your business?	☐ Yes ☐ No		
Period when you are able to attend to a portion of your usual business or occupation			
Period when you are able to attend to the whole of your usual business or occupation.			
Did you receive compensation from any other sources?	☐ Yes ☐ No If yes, please state where and amount _____		
Are you insured elsewhere?	☐ Yes ☐ No If yes, please give full particular		

Insurance Company	Policy Number	Period of Insurance	Amount Insured

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

Date: _____ Signature of Insured: _____

INDIA INTERNATIONAL INSURANCE PTE LTD

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