



Universal Sampo General Insurance Co. Ltd.

(A joint venture between Allahabad Bank, Sampo Japan Insurance Inc., Indian Overseas Bank, Karnataka Bank and Dabur Investments.)

Regd. Office: 201-208, Crystal Plaza, Opp. Infiniti Mall, Link Road, Andheri (West), Mumbai - 400 058.

PERSONAL ACCIDENT CLAIM FORM

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

- Claim form is to be filled in capital letter & signed by the insured/claimant.
- Please do not leave any column unanswered.
- Please read carefully the attached list of documents required to speed up processing of your claim.
- If there is insufficient space, kindly use a separate sheet which can be attached to this form.

Claim No.

A. DETAILS OF INSURED

First Name			Middle Name			Last Name		
Name of the Insured								
First Name			Middle Name			Last Name		
Name of the Claimant								
Relationship with Insured						Designation (If applicable)		
Date of Birth			Sex ☐ Male ☐ Female			Email ID		
Communication								
Address								
City/Taluka			District			State		
Pin Code			STD code			Phone No.		
						Mobile No.		

B. DETAILS OF POLICY

Policy No.			
Period of insurance from to Sum Insured			

C. DETAILS OF OTHER POLICIES

Have you been insured under any Personal Accident Policy of any other insurance companies?		☐ Yes ☐ No
If "Yes", please enclose photocopies of all previous policies.		
Date of commencement of very first insurance for the Beneficiary with continuous insurance coverage?		from to

D. DETAILS OF INCIDENT

Description of accident	
Cause of accident	
Date of accident	Time of accident : AM/PM.
Place of accident	
Accident Reported to	
Are there any witness to accident	☐ Yes ☐ No
Names and Address of witnesses	

Was the insured person moved to hospital immediately after the incidence		☐ Yes	☐ No
If "Yes", please fill in the following			
Date of admission		Time of admission	: AM/PM.
Date of discharge		Time of discharge	: AM/PM.
Name of the Hospital			
Address			
City/Taluka		District	
Pin Code		STD code	
		Phone No.	
		Mobile No.	
Particulars of treatment			
Was the deceased under influence of drugs or alcohol at the time of accident?		☐ Yes	☐ No
Has the accident resulted into;			
Loss of hand	☐ Yes	☐ No	
Loss of foot	☐ Yes	☐ No	
Loss of eye	☐ Yes	☐ No	
Loss of hands	☐ Yes	☐ No	
Loss of feet	☐ Yes	☐ No	
Loss of eyes	☐ Yes	☐ No	
Disability of any other type which may prevent the insured from engaging in or being occupied with or giving attention to any employment or occupation whatsoever			

I hereby certify that _____ was treated by me on _____ for _____ which first incurred on _____ and is related to the incident mentioned above.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

The ailment was caused by / in any way associated with the below mentioned conditions;

Pregnancy or childbirth	☐ Yes ☐ No	Intentional Self Injury	☐ Yes ☐ No
War and allied peril	☐ Yes ☐ No	Nuclear Perils	☐ Yes ☐ No
On duty with any armed forces	☐ Yes ☐ No	Mental disease	☐ Yes ☐ No
Intentional self injury	☐ Yes ☐ No	Use of Intoxicating drugs and alcohol	☐ Yes ☐ No
HIV, AIDS	☐ Yes ☐ No	Venereal disease or sexually transmitted disease	☐ Yes ☐ No

He / She is suffering from

Permanent Total Disability	☐ Yes ☐ No	Temporary Total Disability	☐ Yes ☐ No
Permanent Partial Disability	☐ Yes ☐ No		

Details of the disability _____

Name of the treating Medical Practitioner

First Name	Middle Name	Last Name
_____	_____	_____

Registration No. _____ Qualification _____

Date: _____

Place: _____

Stamp and Signature of the Medical practitioner

	Description	Amount (Rs.)
(A)	Death	
(B)	Permanent Total Disability	
(C)	Permanent Partial Disability	
(D)	Temporary Total Disability	
(E)	Transportation cost for carriage of dead body to Home including funeral charges.	
(F)	Ambulance charges for transportation of Insured person to Hospital following Accident	
(G)	Education Fund	
(H)	Medical Expenses Extension	
(I)	Hospital Confinement Allowance	
(J)	Any other	
TOTAL AMOUNT CLAIMED		

☐ Claim form duly signed	☐ Policy copy	☐ Claim intimation
☐ FIR/ MLC copy	☐ Death certificate	☐ Post mortem report
☐ Inquest / Coroner's report	☐ Final police report	☐ Leave certificate
☐ Investigation reports	☐ Medical certificate	☐ Nominee certificate
☐ Disability Certificate	☐ Employer Certificate	☐ Photograph of the injured with reflecting disablement
☐ Any other documents		

If "Yes", please specify

Any other information
You wish to state

This is to certify that Mr./Ms. , working as , permanent Employee Id No. covered under Personal Accident Policy No. / / / was on leave for the period to Sum Insured. The total numbers of employees on permanent rolls as on the date of accident were

The above information is true to the best of my knowledge and we agree to provide any further information that may be required.

Date: Signature of Authorized signatory:

Place: Name of the Authorized signatory:

Company Seal

I hereby warrant the truth of foregoing statement and sincerely declare that I have not suppressed or concealed any information that is material to this claim. I understand that false declaration/s may result in USGI being able to refuse to pay the claim.

The receipt of this claim form/ other supporting / related document does not constitute or be deemed to constitute an agreement by the USGI of the claim and the USGI reserves the right to process or reject or require further / additional information in respect of the claim.

Date:		Signature of Claimant:	
Place:		Name of the Claimant:	

K. TO BE COMPLETED BY NOMINEE IN THE EVENT OF INSURED'S DEATH

First Name	Middle Name	Last Name
Name of the Nominee		
Relationship with Claimant		
Date of Birth	Sex ☐ Male ☐ Female	Email ID
Communication		
Address		
City/Taluka District State		
Pin Code	STD code	Phone No. Mobile No.
If nominee is minor, kindly provide the Legal Guardian details		
First Name	Middle Name	Last Name
Name of the legal Guardian		
Address		
City/Taluka District State		
Pin Code	STD code	Phone No. Mobile No.
Date of Birth	Sex ☐ Male ☐ Female	Email ID

I/We hereby declare and warrant the truth of the foregoing particulars in every respect. I/We agree that if I/We have made or shall make false or untrue statement, suppression or concealment, my/our right to compensation shall be forfeited.

I/We also hereby declare that I am/we are accepting the amount in full discharge of your obligations under the policy to the Insured Person and /or his/her legal heirs. I/we will hold you indemnified in the event of any claim under this policy being made against you by any other person or persons.

Date: **Signature of Nominee / Legal Guardian:**Place: **Name of Nominee / Legal Guardian:**