



**GROUP PERSONAL  
ACCIDENT  
INSURANCE**

**CLAIM FORM**

*(Company does not admit liability by the issuance of this form)*

1. Policy Number -----
2. Name of Insured -----
3. Address of the Insured -----
4. E- mail address -----
5. Insured's Mobile number -----
6. Name of Claimant -----
7. Claimant's Date of Birth -----
8. Address of Claimant -----  
-----
9. Claimant's Mobile number -----
10. When and where did the accident occur? -----  
-----
11. How did the accident occur? -----  
-----  
-----
12. What is the nature and extent of injuries sustained? -----  
-----
13. Name and address of Doctor who first attended to the Insured after the accident -----  
-----

14. Name and address of usual medical Attendant -----  
-----
15. Is the Insured covered in respect of personal accident risks? If so, with whom(including friendly societies or Benefit societies) -----  
-----
16. Has the Insured ever made a claim or received any payment under such insurance? If so, please state amount(s) and dates -----  
-----
17. Has the Insured ever made a claim or received any payment under this policy? If so, please state amount(s) and dates? -----  
-----
18. As a result of this accident, has the Insured been totally disabled or incapacitated from attending in any way to his usual business, occupation or business of any kind? -----  
-----
19. From what other injuries or illnesses has the insured suffered and when? -----  
-----

**Declaration**

I ----- do hereby declare that the information given above is true and correct to the best of my knowledge.

Signature ----- Date -----

**Witness**

Name ----- Address -----

Signature ----- Date -----