UNITED INDIA INSURANCE COMPANY LIMITED

REGD & HEAD OFFICE: NO 24 WHITES ROAD CHENNAI – 600 014

Policy No. (Bank of Baroda)	**1202004225P102339865 Policy Type -C**	**Address:** **Defence Banking Vertical** **7th Floor, Bank of Baroda Building,** **16, Sansad Marg, New Delhi – 1100 001** **Ph:- 011 2344 8826** **Email:- defenceclaims@bankofbaroda.co.in**
Police Period	**04-05-2025 to 18-10-2025**	

The issue to this form is not to be taken as an admission of Liability

Personal Accident Insurance Claim Form (Particulars) of Accident)

Policy No. _____

Claim No.

TO BE COMPLETED BY THE INSURED

1. (a) Name of the Insured [in full] _____
   (b) Name of the injured Person
   (c) Address in full
   (d) Profession or occupation
   (e) Age at last birthday

2.

	Policy No.	Sum Insured	Table of Cover	Period
(i)				
(ii)				
(iii)				

3	a) Date of the accident? Time of accident? Place of Accident? Name and address of witness	
4	How did the accident occur ?	

5.	Nature of injury received (If to limb or eye state whether right or left)	
6.	a) Nature of disablement Extent of disablement Confined to bed Confined to house b) Present state of incapacity	 [from _____ To _____] [from _____ To _____]
7.	Name and address of surgeon in attendance	
8.	a) Where and when can a Medical Officer of the Company visit you, if necessary ? Name of nearest railway station and distance therefrom	
9.	(i) Are you insured in any other office or offices granting compensation for accident If so state name and address of company or companies and amount of insurance	

I hereby declare that the foregoing statements are made by myself and are true in all respect and that I have not attempted to conceal from the Company anything which it ought to be made acquainted and also that I have not abstained from any usual occupation longer than absolutely necessary and I agree that if I have made, or in any further declaration the Company may require, shall make any false or fraudulent statement or any suppression, concealment or untrue averment whatever, the Policy shall be void and my right to compensation forfeited and am willing, if required to make a Statutory Declaration before a Justice of the Peace of the truth of the whole of the foregoing statement or any other statement I may make a connection with this claim.

Witness:

Name_____ Signature of the Insured_____

Signature Date :
Date
Address

CERTIFIED TO BE FILLED UP AND SIGNED BY AN EYE WITNESS TO THE ACCIDENT

I hereby certify that I was present when the Accident occurred to Mr._____ On the _____ day of _____ 20 ___ in the manner stated by him over leaf, that it was caused by _____ which * was / was not his willful act and that he * was/was not under the influence of intoxicating liquor at the time

Signature

_____

Address _____

* Strike out which is not applicable Occupation _____

Date _____

MEDICAL CERTIFICATE

Claims must be Supported by medical Evidence furnished by the Insured and at his expense.

1. (a) Name of Claimant (b) Sex (c) Age

2. (b) Nature and cause of accident

(b) If to eye or 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 how long ?

1. Is Claimant suffering from any disease or illness apart From his injury and is there any illness by circumstances Which may tend to retard recovery? If so, give particulars?

2. Present Condition

7. How long from the happening of the Accident do you consider Total disablement will last ?

Having personally examined the above named Insured I certify that the above statements are correct and that the injured person is necessarily disabled by the Accident referred to

Signature

_____

Name & Qualification_____

Address __ _____

Date _____

REMARKS FOR EXTRA DETAILS