IFFCO-TOKIO GENERAL INSURANCE CO. LTD

Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi-110017

Claim No:

IFFCO- Tokio Drone Rakshak Insurance Policy - Claim Form

UIN: IRDAN106RP0029V01202223

• Please note that this Claim Form is issued without 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 within 15 days from the date of occurrence

INSURED PERSON'S DETAILS (Please fill all the details in CAPITAL Letters)

Policy No.					
Claimant Name					
Insured Name					
Address					
City		State		Pin Code	
Email Address			Mobile No.		
KYC Details (Please attach self-attested photo copies)					
☐ PAN No.	☐ AADHAR No.	☐ Any other (Please Specify)_____			
KYC Document Number					

Claim under which Benefits (Please Tick the Appropriate Box)

Accidental Death ☐	Permanent Total Disablement (PTD) ☐	Hospitalization Expenses due to Accident ☐

Details of Accident / Incident

Date of Accident / Incident	DD/MM/YYYY	Time		AM/PM
Details of Accident / Incident				
Accident/Incident Address				
City		State		Pin Code
Has the loss been reported to Policy Authority? Yes ☐ No ☐				
If No reason for not reporting				
First Information Report No (F.I.R)		Medico Legal Case No (MLC)		
Is there any Accidental Hospitalization ? Yes ☐ No ☐				
If Yes, Please Confirm	Date of Admission DD/MM/YYYY AM/PAM		Date of Discharge DD/MM/YYYY AM/PM	
Name of the Hospital				

Address of the Hospital					
City		State		Pin code	
Email ID		Contact No			
Name of the Treating Doctor					

Details of others Insurance

S No.	Name of Insured Person	Policy No.	Name of Insurance Co.	Sum Insured	Period of Insurance	
					From	To
1						
2						

Details of Nominee (To be filled in case of Insured's Death)

Nominee Name		Relationship with Insured			
Nominee Address					
City		State		Pin code	
Email ID		Mobile No.			

Payee Details

Bank Name		Branch Nam	
Bank Account No		IFSC Code	
In Support of Bank Details (Please tick the proof submitted)			
Cancelled Cheque ☐		Bank Passbook Copy ☐	

DECLARATION

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize the You to seek necessary information/ documents (including medical) from any hospital / Medical Practitioner / Police / Bank/ Network provider. I hereby declare that I have included all the documents for the purpose of this claim.

Date

Signature of the account holder

Place:

Name of Account holder

ANNEXURE I (Medical Certificate –To be filled by Treating Doctor)

Name of the Patient				IP Registration No			
Gender	Male ☐ Female ☐			Date of Birth	DD/MM/YYYY		
Date of Admission	DD/MM/YYYY	Time AM/PM		Date of Discharge	DD/MM/YYYY	Time AM/PM	
Hospitalization due to Injury	Yes ☐ No ☐ , If Yes Please give cause						
Cause of Accident / Incident							
Details of Injuries sustained							
Nature of Disablement	Permanent Total Disablement Yes ☐ No ☐						
Details of Disablement							
Details of Treatment Given							
According to Doctor , how long should the patient be confined to bed/house , as the direct and sole consequence of the Injury sustained ? From DD/MM/YYYY To DD/MM/YYYY							
Total Claimed Amount							
I certify that I have examined the above named Patient , the above statement are true & correct.							
Name of the Treating Doctor							
Qualifications				Registration No			
Address of Hospital							
City		State		Pin Code			
Contact Details		Email ID					

Date DD/MM/YYYY

Signature of the Doctor with Stamp