IFFCO-TOKIO GENERAL INSURANCE CO. LTD

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

ADDRESS OF POLICY ISSUING OFFICE

Claim No.: _____ **Date of Issue:** _____

ALL IN ONE HOME PROTECTOR POLICY

UIN: IRDAN106RP0064V01201819

SECTION 8 - PERSONAL ACCIDENT INSURANCE CLAIM FORM

1. 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.
2. 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.
3. In case of a death claim, please return this form duly completed together with Death Certificate from the Hospital or the Medical Attendant, Post Mortem Certificate, and Police Panchanama, if any, in;
4. Should there be delay in obtaining any documents relating to the claim, kindly return this Claim Form, duly filled and signed, first to Our Policy Issuing Office (mentioned in the Policy Schedule).

Policy No.	
Limits of Liability under the Policy	
Date & Time of Loss	
Name of Claimant (in full) [If more than one, state names of all] Full Postal Address Relationship of Claimant with the deceased (in case of a death claim)	
State the benefit under which the claim is preferred	
Particulars of the Insured Person i) Name (in full) ii) Postal Address iii) Occupation iv) Age at the time of the accident	
When did the accident happen? (Please give date and exact time) Where did the accident happen? Please give full description of the accident, its cause and injuries sustained State date, time and place of death (in case of a death claim)	

On which date did the claimant receive information with regard to the accident and from whom?	
Please give the names and addresses of two persons who witnessed the accident	
Was the Insured person free from infirmity at the time of accident? If not, give particulars. Was the Insured person under the influence of drugs or alcohol at the time of accident? Is the Claimant satisfied that the death was directly due to the accident? Please give the names and addresses of the Hospital, Clinic or Nursing Home where the Insured Person was treated after the accident. The Medical Practioner / Surgeon who attended on the Insured Person after the accident Regular Physician of the Insured Person, if any	
Does the Insured Person have any other Accident Insurance on his life? If so, state the name of the Insurer/s and amount/s claimed.	

I/We, declare that all statements made on this form are true to the best of my/our knowledge and belief.

I/We agree that if I/We have made, or in any further declaration the Company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited, and the Policy shall be null and void.

Signature of Witness

Name:

Address:

Place:

Signature of Claimant

Date: