PERSONAL ACCIDENT CLAIM FORM

THE ORIENTAL INSURANCE COMPANY LTD.

Regd. Office: Oriental House A-25/27, Asaf Ali Road, New Delhi-110 002

This form is issued without admission of liability, and must be completed and returned within 7 days after its receipt.
No claim can be admitted unless the medical certificate overleaf be furnished at the expense of the Claimant

Claim No. _____	Policy No. _____

1. Name in Full _____ Residencial Address _____ Business Address _____ Profession/Business or Occupation if more than one state all } _____	Present age Years Height Ft. Weight in Kgs.

2. (a) When did accident occur? State day, date and hour (b) Where did it occur? (c) Give full particulars of the cause and the injuries sustained	(a) (b) (c)
3. Give name and address of the witnessess of the accident	
4. (a) Give name and address of the Doctors who attended you (b) Name and address of your Ordinary Medical Attendant	(a) (b)
5. State where and when a Medical or other Officer of the Company can visit you, if necessary	

	TO BED OR ROOM	TO HOUSE
6. (a) State of the number of days you have been necessarily and entirely confined to Bed, Room or House, as the sole and direct result of the injuries sustained (b) If still confined to any, state which (c) Have you in any way attended to business or work during the above period? (d) Have you been able to attend to any portion of your business or occupation and if so from what date?	For _____ days from _____ to _____ (Both inclusive)	For _____ days from _____ to _____ (Both inclusive)
	(b) (c) (d)	
7. Have you previously claimed or received compensation under an Accident and/or Sickness Policy ? If so, please give particulars		
8. (a) Are you insured elsewhere? (b) If so, give the name of each Company or insurer and amount you are entitled to claim	(a) (b)	

I HEREBY DECLARE that I have received the injuries above described, and warrant the truth of the foregoing particulars in every respect, and I agree that if I have made, or shall make false or untrue statement, suppression or concealment my right ot compensation shall be absolutely forfeited

I Claim to be paid the sum of ..... per week, or the total sum of.....which I agree to accept in full settlement of my claim of the company.

Date.....

Place.....

Signature:.....

PRIVATE & CONFIDENTIAL MEDICAL REPORT

THE ORIENTAL INSURANCE COMPANY LTD.

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Note: This form is to be completed by the Claimant's Medical Attendent whose replies should be as full as possible

Policy No. _____	Claim No. _____
1. Claimant Name in Full .....Age.....	
2. The nature and extent of injuries (if to a limp state whether, right or left)	
3. The cause of the accident, so far as known to you	
4. (a) Date of your first attendance upon him in consequence of the injuries sustained (b) Are you still in attendance?	(a) (b)
5. Are you his usual Medical attendant and if so, how long have you known him and for what have you attended him?	
6. (a) Are his symptoms [i] due exclusively to the accident or [ii] traceable to disease, infirmity or any other cause? (b) Has he ever suffered from Gout, Rheumatism, Diabetes or Fits? (c) Is there anything in his medical history which may have contributed directly or indirectly, to the accident or which may be likely to retard his recovery? (d) Have you any reason to suppose that he was under the influence of intoxicants at the time of the accident?	(a) (i) (ii) (b) (c) (d)
7. State the time within your own knowledge that the claimant has been as the direct and sole consequence of the injuries sustained necessarily confined to his bed, room or house If still so confined state to which, and the probable duration confinement to	TO BED OR ROOM _____ _____ from _____ to _____ (Both inclusive)
	TO HOUSE _____ _____ from _____ to _____ (Both inclusive)
8. (a) Has he been able to attend to any portion of his business or occupation? (b) If so, from what date? (c) If not, please state probable date [i] of his being able [ii] of his complete recovery?	(a) (b) (c) (i) (ii)
9. Is there now any disability? If not please give date of recovery?	
10.Any furhter remarks	

I hereby certify that the above named met with the accident referred to and that the foregoing statements are correct.....Qualification.....

Name & Signature

Address.....Date.....

TOTAL DISABLEMENT occurs when the Insured is wholly prevented from attending to his business occupation.
PARTIAL DISABLEMENT when prevented from attending to a substantial portion thereof.