

THE NEW INDIA ASSURANCE COMPANY LIMITED

(A Government of India Undertaking)

Regd & Head Office : New India Assurance Building,

87, Mahatma Gandhi Road, Bombay – 400 001.

PMKVY PERSONAL ACCIDENT INSURANCE POLICY CLAIM FORM

The issue of this form is not to be taken as an Admission of liability.

CLAIM NO. _____

SECTION I (TO BE FILLED IN FOR ALL CLAIMS)

1. (a) Insured's Name _____

(b) Address: _____

(C) Age: _____

2. (a) Policy No. _____

(b) Certificate Holding No. _____

(c) Period From _____ to _____

(d) Issued at _____

3. (a) Particulars of accident: Date Time Place

(b) Whether reported to Police Yes/No

(c) Whether published in any newspaper Yes/No

4. (a) Were you removed to hospital immediately after the accident? Yes/No

(b) If yes, address of the hospital

SECTION II (TO BE FILLED IN BY HOSPITAL AUTHORITIES IN THE EVENT OF PERMANENT DISABLEMENT)

1. Name and address of the hospital: _____

2. Date of admission: _____

3. Date of Discharge: _____

4. (a) Nature of injury: _____

(b) Particulars of treatment: _____

5. Has the accident resulted into loss of hand/s or foot/feet or eye/s permanent disability of any other type which may prevent the insured from engaging in or being occupied with or giving attention to any employment or occupation whatsoever?

If yes, please give details

Date _____

Rubber Stamp of Hospital Signature of the Competent Authority

Of Hospital/Nursing Home with designation

SECTION III (TO BE COMPLETED BY NOMINEE IN THE EVENT OF INSURED'S DEATH)

Details of Nominee

1. Full Name: _____

2. Address: _____

1. Age: _____

2. Relationship with the deceased: _____

Date: _____

Signature of the Nominee

Please attach the following documents in case of death :

1. Original Death certificate on the prescribed format as per State Govt. issued by the
 2. Competent Authority of Govt. Hospital.
 3. Post Mortem Report, if applicable.
 4. First Information Report (FIR).
 5. Panchnama, if applicable.
 6. Newspaper cutting, if applicable.
 7. Original Policy document with receipt.
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Declaration to be signed by the Insured/Claimant or by a Nominee (in the event of insured's death)

I/WE HEREBY DECLARE and warrant the truth of the foregoing particulars in every respect. I/WE agree that if I/WE have made, or if, shall make false or untrue statement, suppression or concealment, my/our right to compensation shall be forfeited.

I/WE ALSO HERE DECLARE that I am /we are accepting the amount in full discharge of your obligations under the policy to the insured and/or his/her legal heirs and I/WE will hold you indemnified in the event of any claim under this policy being made against you by any other person or persons.

Date _____ Signature _____