



युनाइटेड इंडिया इन्श्युरेन्स कं. लि.  
**UNITED INDIA INSURANCE CO. LTD.**  
(Regd. & Head Office : 24, Whites Road, Chennai - 600 014)  
DIVISIONAL / BRANCH OFFICE.....

**PERSONAL ACCIDENT INSURANCE CLAIM FORM.**  
[ For Disablement Claims only ]

The issue of this form does not constitute admission of liability. Please return the form duly completed within Fourteen days of the accident together with the relevant prescriptions, bills, receipts etc.

Note : The words " Injured person" may be read as " Insured" if the insured and the injured person are one and the same.

Claim No.	Policy No.
1. INSURED a. Name b. Address c. Phone No.	a. b.
2. INJURED PERSON a. Name b. Address c. Occupation [if more than one state all] d. Age next birthday e. Height f. Weight	a. b. c. d. Years e. Cms. f. Kgs.
3. a. When did the accident happen? [Please state date and exact time] b. Where did the accident happen c. Give full description of the accident its cause and injuries sustained d. Was the injured person under the influence of drugs or drinks at the time of the accident? e. Give the names and addresses of Witnesses if any to the accident	a. b. c. d. e.

P.T.O.

<p>4. a. Give details of medical attention given and the name and address of the <b>Medical Attendant</b>.</p> <p>b. If the Medical Attendant named above is not the injured person's usual <b>Medical Attendant</b>, give the name and address of his usual Medical Attendant.</p> <p>c. Has he or any other <b>Medical Attendant</b> treated the injured person previously for any illness or injury?</p> <p>d. State where a <b>Medical Officer of the Company</b> can visit the injured person, if necessary</p>	<p>a.</p> <p>b.</p> <p>c.</p> <p>d.</p>
<p>5. State the period during which injured person has been</p> <p>a. Confined to bed / house and <b>unable to attend to his normal duties , at all</b></p> <p>b. Partially able to attend his <b>normal duties</b>, Whether confined to house/ bed or not</p>	<p>a. From To</p> <p>b. From To</p>
<p>6. State date on which the injured person has been/ will be able to resume <b>normal duties</b></p>	
<p>7. a. Has the injured person made any claim or received compensation under any policies of Accident or sickness in the Past? If so, give particulars.</p> <p>b. State whether the injured person holds any other Accident Policy. If so, give the name (s) of the insure (s)</p>	<p>a.</p> <p>b.</p>

I / We hereby declare that the person a named above has injuries described above and that the foregoing particulars are true in every respect.

Signature of insured

Place :

Date :

Signature of injured person