Universal Sompo General Insurance
Suraksha, Hamesha Aapke Saath

Universal Sompo General Insurance Co. Ltd.

(A joint venture between Indian Bank, Sompo Japan Insurance Inc., Indian Overseas Bank, Karnataka Bank and Dabur Investments.)

Regd. Office: Office No 103, First Floor, Ackruti Star, MIDC Central Road, Andheri (East), Mumbai - 400093.

PERSONAL ACCIDENT CLAIM FORM

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

a) Claim form is to be filled in capital letter & signed by the insured/claimant.
b) Please do not leave any column unanswered.
c) Please read carefully the attached list of documents required to speed up processing of your claim.
d) If there is insufficient space, kindly use a separate sheet which can be attached to this form.

Claim No. ____________________

A. DETAILS OF INSURED

	First Name	Middle Name	Last Name
Name of the Insured			
Name of the Claimant			

Relationship with Insured ________ Designation (If applicable) ________

Date of Birth ________ Sex ☐ Male ☐ Female Email ID ________

Communication Address ________

City/Taluka ________ District ________ State ________

Pin Code ________ STD code ________ Phone No. ________ Mobile No. ________

B. DETAILS OF POLICY

Policy No. ____ / ________ / ____ / ____

Period of insurance from ________ to ________ Sum Insured ________

C. DETAILS OF OTHER POLICIES

Have you been insured under any Personal Accident Policy of any other insurance companies? ☐ Yes ☐ No
If "Yes", please enclose photocopies of all previous policies.

Date of commencement of very first insurance for the Beneficiary with continuous insurance coverage? from ________ to ________

D. DETAILS OF INCIDENCE

Description of accident ________

Cause of accident ________

Date of accident ________ Time of accident ___ : ___ AM/PM.

Place of accident ________

Accident Reported to ________

Are there any witness to accident ☐ Yes ☐ No

Names and Address of witnesses ________

E. DETAILS OF HOSPITAL

Was the insured person moved to hospital immediately after the incidence ☐ Yes ☐ No

If "Yes", please fill in the following

Date of admission ☐☐☐☐☐ Time of admission ☐☐ : ☐☐ AM/PM.

Date of discharge ☐☐☐☐☐ Time of discharge ☐☐ : ☐☐ AM/PM.

Name of the Hospital

Address

City/Taluka District State

Pin Code STD code Phone No. Mobile No.

Particulars of treatment

Was the deceased under influence of drugs or alcohol at the time of accident? ☐ Yes ☐ No

Has the accident resulted into;

Loss of hand	☐ Yes	☐ No	Loss of hands	☐ Yes	☐ No
Loss of foot	☐ Yes	☐ No	Loss of feet	☐ Yes	☐ No
Loss of eye	☐ Yes	☐ No	Loss of eyes	☐ Yes	☐ No

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

F. DOCTOR'S DECLARTION

I hereby certify that ______ was treated by me on ______

for ______ which first incurred on ______ and is related to the incident mentioned above.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

The ailment was caused by / in any way associated with the below mentioned conditions;

Pregnancy or childbirth	☐ Yes	☐ No	Intentional Self Injury	☐ Yes	☐ No
War and allied peril	☐ Yes	☐ No	Nuclear Perils	☐ Yes	☐ No
On duty with any armed forces	☐ Yes	☐ No	Mental disease	☐ Yes	☐ No
Intentional self injury	☐ Yes	☐ No	Use of Intoxicating drugs and alcohol	☐ Yes	☐ No
HIV, AIDS	☐ Yes	☐ No	Venereal disease or sexually transmitted disease	☐ Yes	☐ No

He / She is suffering from

Permanent Total Disability	☐ Yes	☐ No	Temporary Total Disability	☐ Yes	☐ No
Permanent Partial Disability	☐ Yes	☐ No			

Details of the disability

Name of the treating Medical Practitioner: First Name / Middle Name / Last Name

Registration No. Qualification

Date:

Place:

Stamp and Signature of the Medical practitioner

G. DETAILS OF CLAIMED AMOUNT

	Description	Amount (Rs.)
(A)	Death	
(B)	Permanent Total Disability	
(C)	Permanent Partial Disability	
(D)	Temporary Total Disability	
(E)	Transportation cost for carriage of dead body to Home including funeral charges.	
(F)	Ambulance charges for transportation of Insured person to Hospital following Accident	
(G)	Education Fund	
(H)	Medical Expenses Extension	
(I)	Hospital Confinement Allowance	
(J)	Any other	
TOTAL AMOUNT CLAIMED		

H. ENCLOSURES

☐ Claim form duly signed ☐ Policy copy ☐ Claim intimation

☐ FIR/ MLC copy ☐ Death certificate ☐ Post mortem report

☐ Inquest / Coroner's report ☐ Final police report ☐ Leave certificate

☐ Investigation reports ☐ Medical certificate ☐ Nominee certificate

☐ Disability Certificate ☐ Employer Certificate ☐ Photograph of the injured with reflecting disablement

☐ Any other documents

If "Yes", please specify

Any other information You wish to state

I. EMPLOYER'S DECLARATION

This is to certify that Mr./Ms _____, working as _____, permanent Employee Id No. _____ covered under Personal Accident Policy No. _____ / _____ / _____ / _____ was on leave for the period _____ to _____ Sum Insured. _____ The total numbers of employees on permanent rolls as on the date of accident were _____ The above information is true to the best of my knowledge and we agree to provide any further information that may be required.

Date: _____ Signature of Authorized signatory:

Place: _____ Name of the Authorized signatory: _____

Company Seal

J. INSURED'S / CLAIMANT'S DECLARATION

I hereby warrant the truth of foregoing statement and sincerely declare that I have not suppressed or concealed any information that is material to this claim. I understand that false declaration/s may result in USGI being able to refuse to pay the claim.

The receipt of this claim form/ other supporting / related document does not constitute or be deemed to constitute an agreement by the USGI of the claim and the USGI reserves the right to process or reject or require further / additional information in respect of the claim.

Date: _____ Signature of Claimant:

Place: _____ Name of the Claimant: _____

K. TO BE COMPLETED BY NOMINEE IN THE EVENT OF INSURED'S DEATH

First Name | Middle Name | Last Name

Name of the Nominee

Relationship with Claimant

Date of Birth Sex ☐ Male ☐ Female Email ID

Communication

Address

City/Taluka District State

Pin Code STD code Phone No. Mobile No.

If nominee is minor, kindly provide the Legal Guardian details

First Name | Middle Name | Last Name

Name of the legal Guardian

Address

City/Taluka District State

Pin Code STD code Phone No. Mobile No.

Date of Birth Sex ☐ Male ☐ Female Email ID

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 shall make false or untrue statement, suppression or concealment, my/our right to compensation shall be forfeited.
I/We also hereby declare that I am/we are accepting the amount in full discharge of your obligations under the policy to the Insured Person and /or his/her legal heirs. 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:

Place:

Signature of Nominee / Legal Guardian:

Name of Nominee / Legal Guardian: