ICICI Lombard
GENERAL INSURANCE

ICICI LOMBARD GENERAL INSURANCE COMPANY LIMITED

Regd. Office: ICICI Bank Towers, Bandra Kurla Complex, Bandra (East), Mumbai – 400 051

CLAIM FORM FOR PERSONAL ACCIDENT INSURANCE

(The issue of this form is not to be taken as an Admission of Liability)

PLEASE ANSWER ALL QUESTIONS FULLY

1.	**DETAILS OF INSURED**	
(I)	Name	
(ii)	Address for Correspondence	
(iii)	Contact No.	
2.	**DETAILS OF INJURED/ DECEASED PERSON**	
(i)	Name	
(ii)	Address	
(iii)	Age	
(iv)	Designation	
(v)	Date & time of injury/death	
(vi)	Place of injury/ death	
(vii)	Details of the accident	
(viii)	Whether reported to Police.	Yes/ No
(ix)	If yes then name and address of Police Station.	

3.	Was the injured /deceased person moved to hospital immediately after the accident? If yes , Name & address of the hospital	Yes/ No
4.	Do you have any other Personal Accident Policy? If yes, please give :	
(i)	Address of the issuing office	
(ii)	Policy No.	
(iii)	Period	

Declaration

I hereby agree, affirm and declare that:

(a) The statements/information given/stated by me/us in this claim form are true, correct and complete.

(b) No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.

(c) If I have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I shall not be entitled to all/any rights to recover thereunder in respect of any or all claims, past, present or future.

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

Place
Date

Signature of the Injured Person

(To be filled in by the Employer/Insured)	
1. Was the injured person in respect of whom claims being made absent from work? If so, please furnish the details of such absence.	Yes/No
I / We hereby declare that the particulars made by the injured person in the claim from are true to the best of our knowledge and belief. Place : Date : Signature of the Insured	

SECTION II (TO BE COMPLETED BY HOSPITAL AUTHORITIES)		
1.	Name and address of the hospital	
2.	Date of admission (As in patient / out patient / emergency case)	
3.	Date of discharge	
4.(i)	Nature of injury	
(ii)	Particulars of treatment	
5. (i)	Has the accident resulted into loss of hand/s or foot/feet or eye/s or 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?	Yes / No
(ii)	If yes, please give details	

Signature of the competent Authority of Hospital / Nursing Home

Date: **Name:**

Official Seal of the Hospital: **Designation**:

SECTION III (TO BE COMPLETED BY NOMINEE IN THE EVENT OF INSURED'S DEATH)		
1.	**Details of Nominee**	
(i)	Full Name	
(ii)	Address	
(iii)	Age	
(iv)	Relationship with the deceased	
Date: Place:		Signature of the Nominee
2.	**Please attach the following documents**	
(i)	Death Certificate	
(ii)	Post Mortem Report	
(iii)	Original Policy document with receipt	

Declaration to be signed by the Insured/ claimant or by the 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 shall make false or untrue statement, suppression or concealment, my/our right to compensation shall be forfeited.

I/we also here by 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 the Nominee**