Royal Sundaram

PERSONAL ACCIDENT DISABLEMENT CLAIM FORM

FOR OFFICE USE ONLY	
Issuing office :	
Date of Issue :	
Claim No :	

ROYAL SUNDARAM ALLIANCE INSURANCE COMPANY LIMITED
46, Whites Road, Chennai-600 014. Telephone : 044-852 2123 Fax: 044-851 7384
E-mail : customer.services@in.royalsun.com

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

Please ensure that all questions are answered in Capital Letters using an ink pen

Policy Number		Certificate Number	
Card Number / Account Number		Name of the Bank	

1. Insured/Insured Person

Name of the Insured/Insured Person	
Name of the injured Person	
Address for Correspondence	
Telephone Daytime / Mobile Number	STD Code :
Telephone Evening	STD Code :
E-mail ID	

2. Details of the accident

Date of the accident	(DD/MM/YY)
Time of accident	(AM/PM)
Place of accident	
Nature and cause of accident	
Was the accident reported to the Police?	Yes ☐ No ☐
If Yes please give the address of the Police Station If No please give reason why	
First Information Report Number & Date	

3. Details of Injury

Nature of injury/disablement (if limb or eye is injured, please state whether right or left)

Period of disablement:

Confined to Bed — From / / (DD/MM/YY) To / / (DD/MM/YY)

Confined to House — From / / (DD/MM/YY) To / / (DD/MM/YY)

Name and Address of the attending physician (with Pin Code) & Phone No.

4. Other Insurance Details

Does the injured person have any other Personal Accident insurance? Yes ☐ No ☐

If yes , please give the name and address of the Insurance company

Policy Number

Amount Insured for

5. DECLARATION

I hereby declare that the foregoing statements are made by myself and are true in all respects. I have not attempted to conceal from the Company anything with which it ought to be made acquainted. I agree that if I have made or in any further declaration that the Company may require, shall make any false or fraudulent statement or any suppression, concealment or untrue averment whatsoever, the Policy shall be void and my right to compensation forfeited. I am willing, if required, to make a Statutory Declaration before a Court of the truth of the whole of the foregoing statement or any other statement I may make in connection with this claim.

Signature / thumb impression of the Insured

Date / / (DD/MM/YY)

CERTIFICATE FROM THE EYE WITNESS TO THE ACCIDENT

I hereby certify that I was present when the accident occurred to Miss/Mrs/Mr. _____ on _____ (DD/MM/YY) in the manner stated overleaf. It was caused by _____ _____

which was*/was not* his/her wilful act and he/she was*/was not* under the influence of intoxicating liquor / drugs at the time of accident.

*Strike out which is not applicable

Date : / / (DD/MM/YY)

Signature / thumb impression of the eye witness

Name

Place

Address

PLEASE CHECK THAT ALL QUESTIONS HAVE BEEN COMPLETED IN FULL & THE FORM SIGNED AND DATED. KINDLY SEND THE FOLLOWING DOCUMENTS

First Information Report - Photocopy duly attested by the issuing authority

Medical certificate forming part of the claim form

Admission / Discharge summary issued by hospital authority

English translation of vernacular documents

Medical bills and cash receipts in original

In case of temporary total disablement, leave certificate from the employer, if in service.

TO BE FILLED IN BY ATTENDING PHYSICIAN

MEDICAL CERTIFICATE FORMING PART OF PERSONAL ACCIDENT DISABLEMENT CLAIM FORM

1. Name and Address of the injured person

2. Age of the injured person

3. Name & Address of the Hospital

4. IP / OP Number

5. Describe nature and extent of injury

6. Nature & cause of accident (so far as it is known to you)

7. Are you still attending on him/her? Yes ☐ No ☐

8. Are you his/her usual Medical attendant? Yes ☐ No ☐

9. If you have treated him/her for any previous Illness or injury, please give details

10. Are his/her injuries-

    a. Solely due to the accident? Yes ☐ No ☐

    b. Traceable to any disease, infirmity previous injuries or any other cause? Yes ☐ No ☐

    If yes , please give details

11. Could the injuries, sustained in this accident be the sole cause of disablement — Yes ☐ No ☐

12. Was he / she to your knowledge under the influence of intoxicants or drugs at the time of accidents? — Yes ☐ No ☐

13. According to you, how long should the injured person be confined to bed / house as the direct and sole consequence of the injury sustained ? — From / / (DD/MM/YY) To / / (DD/MM/YY)

14. During this period will the injured person be able to attend to his/her normal duties ? — Yes ☐ No ☐

a. If yes, form what date? / / (DD/MM/YY)

b. If not, Please state probable date of his / her being able to attend to his normal duties / / (DD/MM/YY)

15. Present Condition

16. Nature of disablement (to be filled ONLY in case of permanent disablement)

a. Permanent Total Disablement — Yes ☐ No ☐

b. Permanent Partial Disablement — Yes ☐ No ☐

If yes please specify percentage:

17. Any other remarks you wish to make

I hereby certify that the injuries sustained by the person mentioned above are in accordance with the nature of the accident as described to me and that I treated him for the said injuries

Doctor s Name

Qualifications

Registration No — Signature of the Doctor

Address — Date

Phone No.

E-mail

Additional Information :