

Regd. Office: Bombay Pune Road, Akrudi, Pune 411 035 & Head Office: GESCO Plaza, Airport Road, Yerawada, Pune 411 006

GROUP PERSONAL ACCIDENT INSURANCE

CLAIM FORM

Policy	Claim No.					
No	Date of reg	istration				
Regional/Branch Office Code			-			
Broker/Agent				Code		
				•	•	
Name of the Insured						
2. Customer ID						
3. Address of the Insured	Plot No/	Door	Bu	ilding		
	No.		nai	_		
	Road		<u>.</u>	•		
	Area					
	City			Pin code		
	State					
	Phone No.					
	E-mail Id		<u> </u>			
4. Profession or Occupation						
Policy details		·				
Sum Insured	Table of C	over				
5. a)Name of the insured person died/						
injured in the accident						
b) Relationship with the employee/ member						
c) Employee/member identification no.		Self/Spo	use/Chil	ldren		
6. a) Date of the Accident						
b) Time of the Accident						
c) Where it happened?						
d) Name & Address of the Witness						
7. How did the Accident occur?						
0 N (CI : 1/2/2 11 1						
8. Nature of Injury received (if to limb	or					
Eye state whether right or left)						

9.	a) Nature of disablement	
	1) 7 6 11 11	
	b) Extent of disablement	
	c) Period of temporary total disablement	(From)
	c) remot or temporary total disastement	(11011111111111111111111111111111111111
	d) Present state of incapacity	
10.	Name and address of Surgeon in attendance	
11.	Where and when can a Medical Officer	
	of our Company visit you, if	
	necessary?	
12.	a) Are you insured in any other Office or	
	Offices granting compensation for	
	accident?	
	b) If so state name and address of company or	
	Companies and amount of Insurance	
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I/We hereby declare that the foregoing statements are true in all respects and that I/We have not attempted to conceal from the company anything with which it ought to be made acquainted and also that if I/We have made or in any further declaration the Company may require shall make any false or fraudulent statement or any suppression, concealment or untrue averment whatever, the Policy shall be void and my/our right to compensation forfeited and am/are willing if required, to make a statutory Declaration before a Justice of the Peace of the truth of the whole of the foregoing statement or any other statement I/We may make in connection with this claim.

Witness: Name	
Signature of the Insured	Date

MEDICAL CERTIFICATE

1. a) Name of Claimant

(b) Age

- 1. a) Nature and cause of Accident
 - b) If to eye or limb, state left or right
 - c) Whether the appearance of the injuries are consistent with the account given of the accident
- 2. Date on which you first attended claimant for this injury
- 3. Has claimant been totally prevented from attending to any portion of his business? If so for how long?
- 4. Is claimant suffering from any disease or illness apart from his injury and is there any illness by circumstances which may tend to retard recovery? If so, give particulars
- 5. Present condition
- 6. How long from the happening of the Accident do you consider
 - a) Total disablement will last
 - b) Partial disablement will last

Having personally examined the above named Insured, I certify that the above statements are correct and that the injured person is necessarily disabled by the accident referred to.

Signature:	
Name:	
Qualification:	
Address:	