THE NEW INDIA ASSURANCE COMPANY LIMITED

Regd & Head Office : New India Assurance Building,
87, Mahatma Gandhi Road, Bombay – 400 001.

BHAGYASHREE CHILD WELFARE CLAIM FORM

The issue of this form is not to be taken as an Admission of liability.
CLAIM NO._____

SECTION I (TO BE FILLED IN FOR ALL CLAIMS)

1. (a) Insured's Name _____

   (b) Address: _____
   _____
   _____
   _____

   (c) Date of birth: _____
   (enclose birth certificate)

   (d) Age: _____

   (e) Name of the school where the insured is studying_____
   _____

   (f) Class of study: _____

2. (a) Name of Father: _____
   (b) Occupation of Father: _____
   (c) Age of Father: _____
   (d) Name of Mother: _____
   (e) Occupation of Mother: _____
   (f) Age of Mother: _____

3. (a) Policy No. _____
   (b) Period From _____to _____
   (c) Issued at _____

4. (a) Name of deceased: _____

(b) Relationship with Insured: _____
(c) Particulars of Accident: _____
(d) Date of Accident: _____
(e) Time of Accident: _____
(f) Place of Accident: _____
(g) Whether reported to police Yes/No, P. S. case No.: _____
(h) Details of cause of death: _____

_____
_____

5. (a) Whether parent removed to hospital immediately after accident: _____
   (b) If yes, address of the hospital: _____

6. (a) Do you have any other similar policy? Yes/ No
   (i) If yes, Name of the company: _____
   (ii) Policy No.: _____
   (iii) Period _____ yrs From _____ to _____
   (iv) Issuing office at: _____

I declare that I have _____ Nos. of female child/ children and I have taken this policy for the benefit of my female child named above and further declare that I have not taken any BHAGYASHREE CHILD WELFARE POLICY in respect of other female children.

I/we the above name do hereby declare to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect and I/we agree that I/we have made, or in any further declaration which the company may required in respect of the said accident, shall make any false or fraudulent statements or any suppression or concealment the policy shall be void and all rights to recover thereunder in respect of past or future accident shall be forfeited.

Date _____ _____

Signature of witness _____ (Signature of the Parent/Guardian)

SECTION II (TO BE FILLED IN BY HOSPITAL AUTHORITIES)

1. Name and address of the hospital: _____
   _____
2. Date of admission: _____
3. Date of death: _____
4. Cause of death: _____
5. Extent of injuries: _____
6. Date of postmortem: _____

Date _____
Rubber Stamp of Hospital

Signature of the Competent Authority
Of Hospital/Nursing Home