



UNITED INDIA INSURANCE CO. LTD.

Registered & Head Office : No. 24, Whites Road, Chennai - 600 014.

Divisional / Branch Office :

PERSONAL ACCIDENT INSURANCE CLAIMANT'S STATEMENT

(The issue of this form does not constitute admission of liability. Please return this form duly completed together with Death Certificate from the Hospital or the Medical Attendent, Post Mortem Certificate and Police Panchanama, if any. Should there be delay in obtaining any forms, kindly return this claim form first to the office which issued the policy).

Claim No.	Policy No.
1. a) Name of Claimant (in full) If more than one state names of all	a)
b) Full Postal Address	b)
c) Relationship of Claimant with the deceased	c)
2. State nature of title under which Claimant is claiming the amount	

PARTICULARS OF THE INSURED PERSON WHO DIED IN THE ACCIDENT

3. a) Name (in full)	a)
b) Last Full Postal Address	b)
c) Last Occupation	c)
d) Age at the time of the accident	d)
4. a) When did the accident happen ? (Give date and exact time)	a)
b) Where did the accident happen	b)
c) Give full description of the accident, its cause and injuries sustained	c)
d) State date, time and place of death	d)
5. On what date did the claimant receive information in regard to the accident and from whom ?	
6. Give the names and addresses of two Persons who witnessed the accident.	

<p>7. a) Was the deceased free from infirmity at the time of accident? If not, give particulars.</p> <p>b) Was the deceased under the influence of drugs or drink at the time of accident?</p> <p>c) Is the Claimant satisfied that the death was directly due to the accident.</p>	<p>a)</p> <p>b)</p> <p>c)</p>
<p>d) Give the names and address</p> <p>i) The Hospital, Clinic or Nursing Home where the deceased was treated after the accident</p> <p>ii) The Physician/Surgeon who attended on the deceased after the accident.</p> <p>iii) His regular Physician if any</p>	<p>i)</p> <p>ii)</p> <p>iii)</p>
<p>8. Did the deceased have any other Accident Insurance on his life? If so, state the name of the Insurer/s and amount/s claimed.</p>	

I/We hereby affirm and declare that the answers to all the above questions are full and true in every respect.

Place :

Date :

Signature of Claimant

Witnesses

1. Signature

Name

Address

.....

.....

2. Signature

Name

Address

.....

.....

Signature of Branch Manager
With Office Seal

Signature of Society Incharge
With Office Seal

चित्तौड़गढ़ केन्द्रीय सहकारी बैंक लिमिटेड, चित्तौड़गढ़ (राज.)
CHITTORGARH KENDRIYA SAHKARI BANK LTD. CHITTORGARH (RAJ.)

HEAD OFFICE-CHITTORGARH-312001

PH-01472-246031, 241401 (Bank) Fax.-01472-241401, Email-cksbchittor@Yahoo.co.in

दुर्घटना बीमा क्लेम हेतु चैक लिस्ट

1. मूल आवेदन पत्र - शाखा प्रबंधक द्वारा हस्ताक्षर एवं दावेदार के हस्ताक्षर युक्त ।
2. मृत्यु प्रमाण पत्र ।
3. किसान क्रेडिट कार्ड (पास बुक एवं समिति खाता) छाया प्रति ।
4. डॉक्टर प्रमाण पत्र/पोस्टमार्टम रिपोर्ट ।
5. पुलिस विभाग - एफ.आई.आर प्रति ।
6. दावाकर्ता का वोटर आई.डी. कार्ड प्रति ।
7. पंचनामा
8. बीमा सूचि का भाग वह पृष्ठ जिस पर मृतक का नाम हो ।
बीमा की कुल राशि, दिनांक.....ताकि पॉलिसी नं. पहचान सकें।
9. मृतक का आयु प्रमाण पत्र, वोटर आई.डी. प्रुफ, समस्त छाया प्रतियां प्रमाणित कराई गई हो । (सरपंच/समिति का अध्यक्ष/ऋण पर्यवेक्षक, सहायक अधिशाषी अधिकारी/क्षेत्र का विधायक/राजपत्रित अधिकारी /पुलिस ए.एस.आई. या एस.आई)