



## UNITED INDIA INSURANCE COMPANY LIMITED

### Loss of License Insurance – Claim Form

THE ISSUE OF THIS IS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY  
The completion and return of this form to the Insurers should not be delayed if any of the particulars required cannot be immediately given. They may be forwarded to the Insurers afterwards as soon as possible.

#### PARTICULARS OF CLAIM

CLAIM NO.....

POLICY NO.....

1 a) Name of the Insured:

b) Address:

2. Age of the Insured Person:

3. Occupation/Profession:

4. Policy Period:

5. Please state in full the nature and extent of the illness you suffered/injuries you sustained :	
6. Please give name and address of the Medical attendant whom you first consulted for this illness/injuries : a) Is he usual Medical Attendants. b) Has any other Medical man been consulted	
7. If you are still disabled, please indicate when you are likely to be fit to resume your usual business or occupation, either wholly or in part	
8. When and where can you be visited (if necessary) by a Medical Officer or an official of the Company	
9. When did you last receive medical attention previous to this illness/injuries	
10. Are you insured with any other office for this insurance. If so, please furnish the name and address of the office and the policy number.	
11. What amount do you claim under our policy. a) Please give details of how this amount has been	

arrived at .	
12. State the following : a) No. and type of your Aviation License b) Date of License and by whom granted c) Date of expiry of License d) Date of last medical examination for license	
13. Has any restriction or qualification has been placed on your license for medical or any other reason before this claim. If so, please give details	
14. Name of the aircrew association of which you are a member	
15. What is your present total annual remuneration from your occupation as a member of aircrew. Please give details i.e Basic Pay, DA etc.	
<b>16. To be filled in, if the Claim relates to injuries :</b> a) Please state when and where the accident took place. b) Please give date, hour and place. c) If accident occurred in an Aircraft, give type and identification mark thereof. d) Please state how the accident happened, what were you doing at that time. e) Whether you were on board the Aircraft as a member of the crew or a passenger. f) Were you in good health and free from physical defects or infinity at the time of accident. g) If at the time of the accident you were flying as a member of aircrew then state the name of your employer or on behalf of whom you were flying.	
<b>16. To be filled in, if the Claim relates to illness :</b> a) When did the illness commenced. b) Have you ever suffered before from the complaint in respect of which you are claiming c) Have you ever made any claim for compensation in respect of any illness with this company or with any other company. Please give details d) Are there any unusual circumstances connected with your occupation or mode of life that would render you more than usually susceptible to disclose.	

I do hereby declare that to the best of my knowledge and behalf the foregoing particulars are true and correct.

Place:

Date:

Signature of the Insured Person/Representative