UNITED INDIA INSURANCE COMPANY LIMITED

(A Govt. of India Undertaking)

Regd. & Head Office: No.24, Whites Road, Chennai-600014

AVIATION PERSONAL ACCIDENT CLAIM FORM

This form is issued without admission of liability, and must be completed and returned within seven days after its receipt. No claim

CLAIM No.	**POLICY No**	
Name in full		Present Age _____ Years
Residence		Height _____ Ft. _____ In _____ Weight ____ __ Kg. _____ Grams ____
Business Address		
Occupation		

2	(a) When did accident occur? State day, date and hour (b) Where did occur (c) Give full particulars of the cause and the injuries sustained	
3	Give name and address of the witness of the accident	
4	(a) Give name and address of the Doctors who attended you (b) Name and address of your ordinary Medical Attendant (C) Name & Address of Hospital where treatment is taken along with all the Medical Certificates, Reports, Discharge Summary etc.	
5	State where and when a Medical or Officer of the company can visit Insured/claimant, if necessary.	
6	(a) State the number of days you have been necessarily and entirely confined to Bed Room of House as the sole and direct result of the injuries sustained (b) If still confined to any state which (c) Have you in any way attended to business or work during the above period (d) Have you been able to attend to any portion of your business or occupation and if so, from what date	
7	Have you previously claimed or received compensation under an Accident and/or Sickness Policy? If so, please give particulars.	
8	(a) Are you insured elsewhere? (b) If so, give the name of each Company or Insurer and amount you are entitled to claim	

I HEREBY DECLARE that I have received the injuries above described and warrant the truth of the foregoing particulars in every respect and I agree that I have made, or if shall make false or untrue statement, suppression or concealment my right to compensation shall be absolutely forfeited.

Place _____ **Signature of Claimant**

Dated _____

PRIVATE & CONFIDENTIAL

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MEDICAL REPORT

NOTE: This form is to be completed by the claimant's Medical Attendant whose replies should be as full as possible

POLICY No CLAIM No

1	CLAIMANT Name in Full	Age
2	The nature and extent of injuries (Is to a limb state whether right or left)	
3	The cause of the accident, so far as known to you	
4	(a) Date of your first attendance upon him in consequence of the injuries sustained (b) Are you still in attendance?	
5	Are you his usual Medical Attendant and if so, how long have you known him and for what have you attended him ?	
6	(a) Are his symptoms (i) due exclusively to the accident or (ii) traceable to disease infirmity or any other cause ? (b) Has he ever suffered from Gout Rheumatism, Diabetes or Fits ? (c) Is there anything in his medical history which may have contributed directly or indirectly to the accident, or which may likely to retard his recovery (d) Have you any reason to support that he was under the influence of intoxicants at the time of the accident	
7	State the time within your own knowledge that the Claimant has been as the direct and sole consequence of the injuries sustained necessarily confirmed to his bed room or house. If still so confined state to which and the probable duration of confinement to	
8	(a) Has he been able to attend any portion of his business or occupation (b) If so from what date? (C) If not please, state probable date (i) of his being so able (ii) of his complete recovery	
9	Is now there any disability? If not please give date of recovery	
10	Any further remarks	

I hereby certify that the above named met with the accident referred to and that the foregoing statements are correct

Signature **Name & Qualification of Doctor**

Address **Date**

TOTAL DISABLEMENT occurs when the Insured is wholly prevented from attending to his business/occupation,
PARTIAL DISABLEMENT when prevented from attending to a substantial portion thereof