UNITED INDIA INSURANCE COMPANY LIMITED

HANDLOOM WEAVERS INSURANCE - CLAIM FORM

(The issue of this form does not constitute admission of liability. Please return this form completed within 14 days of the loss together with the relevant documents.)

Policy No. Claim No.

<table>
<tr><td>1.</td><td colspan="3">a) Name of insured:
b) Address

c) Name of other persons having an Interest in the property</td></tr>
<tr><td>2.</td><td colspan="3">DETAILS OF INSURANCE (including the Policy / Policies taken with our Company)</td></tr>
<tr><td rowspan="3">3.</td><td>Policy No. (s)</td><td>Sum Insured Rs.</td><td>Period
From / To</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>N.B. If Insurance is effected with other Companies, copies of such policies to be attached.</td><td colspan="2"></td></tr>
<tr><td></td><td colspan="3">SECTION I - FIRE & ALLIED PERILS (FOR BUILDING & CONTENTS)
DETAILS OF LOSS / EVENT
a) Time & Date of Loss / Event
b) Cause of Loss / Event
c) Item of Policy effected (given description)
d) Describe in detail the total event giving rise to the claim
e) Has the event / loss been reported to Police or other Authorities?</td></tr>
<tr><td>4.</td><td colspan="3">Extent of Loss (as more particularly described in the Statement overleaf)</td></tr>
<tr><td>5.</td><td colspan="3">SECTION - II BURGLALRY AND HOUSE BREAKING
1. Time and date of occurrence.
2. Details of the act of Burglary noticed and how committed by Burglars.
3. Particulars of property Burgled stolen with details such as
i) Make
ii) Year of acquisition.
iii) Cost price.
iv) Depreciation for wear and tear
v) Net amount claimed
4. How and where the burgled property was stored?
5. Was any Security personnel employed?</td></tr>
<tr><td></td><td colspan="3">SECTION III - PERSONAL ACCIDENT

Please return the claim form (Claimant's Statement) duly completed along with the Medical / Hospital Report vide Annexures I & II attached along with death certificate and post-mortem certificate.</td></tr>
</table>

	SECTION IV - FIDELITY GURANTEE a) Full particulars of circumstances surrounding the loss b) Particulars of loss of money denomination wise and details of cash on hand as per receipts. c) Particulars of pledged gold jewelry d) Full description of article. e) To whom the article belonged f) From whom purchased or received (Name and address) g) Date purchased or received h) Weight i) Cost j) Deduction for wear and tear and depreciation. k) Net amount claimed. Details of Safe or Vaults kept in the premises and keys operation procedure practiced. In the event of loss due to misappropriation of money or gold by employees / dishonesty of appraiser / Pigmy collectors. a) Name of Defaulter and last known address b) State date of discovery of the irregularities and what led to it. c) For how long and in what manner have the embezzlements been carried on and concealed ? d) Has there been any previous irregularity in the Defaulter's accounts ? If so, state nature of same. e) What is the extent of the loss so far as at present ascertained ? f) Do you hold any other security than the above policy in respect of the Defaulter ? g) What salary, commission or other remuneration or allowances is due to him ?	

I/We hereby declare that the statement made by us in the claim form are true to the best of our knowledge and belief and that I / We have to withheld any material information which has bearing upon the claim.

Place:
Date: **Signature of the Claimant**

DETAILS OF CLAIM FOR PROPERTY / LOST / DESTROYED OR DAMAGED

The insurance is based on the principle of indemnity only and all claims must be based upon the actual value of the goods at the time of event excluding any value addition whatsoever.

Item Number of Policy	Description of Affected / Lost Property	Value at the time of event / lost Rs.	Deduction for value of salvage, wherever applicable Rs.	Net Amount Claimed Rs.

ANNEXURE I

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 Attendant, 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] b) Full Postal Address c) Relationship of Claimant with the deceased	a) b) 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) b) Last full Postal Address c) Last Occupation d) Age at the time of the accident	a) b) c) d)
4.	a) When did the accident happen? (Give date and exact time) b) Where did the accident happen? c) Give full description of the accident, its cause and injuries sustained d) State date, time and place of death	a) b) c) 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	
7.	a) Was the deceased free from infirmity at the time of accident? If not, give particulars b) Was the deceased under the influence of drugs or drink at the time of accident? a) Is the Claimant satisfied that the death was directly due to the accident? b) Give the names and addresses of i) The Hospital, Clinic or Nursing Home where the deceased was treated after the accident ii) The Physician / Surgeon who attended on the deceased after the accident i) His regular Physician, if any	a) b) c) d) i) ii) iii)
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	

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

Place :

Date :

Witnesses: **Signature of Claimant**

1. Signature
   Name
   Address

2. Signature
   Name
   Address

ANNEXURE II

PERSONAL ACCIDENT INSRANCE – MEDICAL REPORT (FOR DISABLEMENT CLAIM)

(This form is to be completed and signed by the Medical Attendant)

1.	Name and Address of Insured Person:	
2.	What was the injury ?	
3.	a) When did you first attend on the Insured person following the injury? b) Are you still attending on him?	a) b)
4.	Are you his usual Medical Attendant? If you have treated him for any previous illness or injury, please give details:	
5.	a) According to you, how long the Insured Person was confined to bed/house as the direct and sole consequence of the above injury? b) During this period was the Insured Person able to attend to any portion of his normal duties? If so, from what date: c) If not, please state probable period of convalescence after which he can resume his normal duties fully.	a) b) c)
6.	Any other remarks you wish to make:	

I hereby certify the Insured Person mentioned above has suffered from the disease mentioned above and that I have treated him for the said disease.

Place:

Date :

Signature:

Name:

Seal / Rubber Stamp

Address:

Qualifications:

Regn. No.

Note: The fee, if any, for this Report will be borne by the Insured Person.