UNITED INDIA INSURANCE COMPANY LIMITED

KISAN CREDIT CARD HOLDERS - PERSONAL ACCIDENT INSURANCE

CLAIM FORM

POLICY NO. CLAIM NO.

SECTION I (TO BE FILLED IN FOR ALL CLAIMS)					
1.	a) Insured's Name b) Address c) Age				
2.	a) Policy No. b) Period c) Issued at				
3.	a) Particulars of Accident: b) Details	Date	Time A.M./P.M.	Place	Whether reported to police Yes/ No.
4.	a) Were you removed to hospital immediately after the accident? b) If yes, Name & address of the Hospital			Yes / No	
5.	a) Do you have any other Janatha Personal Accident Policy? If yes, please give: 1. Name of the company 1. Address of the issuing office 2. Policy No. 3. Period			Yes / No	
6	Name of the Bank who covered the Insured under KCC scheme				

SECTION II (TO BE COMPLETED BY HOSPITAL AUTHORITIES)		
1.	Name & address of the Hospital	As in – patient / out patient / emergency case
2.	Date of admission	
3.	Date of discharge	
4.	Nature of injury Particulars of treatment	
5.	a) Has the accident resulted into loss of hand/s or foot/feet or eye/s or permanent disability of any other type which may prevent the Insured from engaging in or being occupied with or giving attention to any employment or occupation whatsoever? b) If yes, please give details	

Signature of the Competent Authority of Hospital / Nursing Home

Date: Name:

Rubberstamp of Hospital: Designation:

SECTION III (TO BE COMPLETED BY ASSIGNEE IN THE EVENT OF INSURED'S DEATH)	
Details of Assignee a) Full Name b) Address c) Age d) Relationship with the deceased Date : Please attach the following documents:- 1. Death Certificate 2. Post Mortem Report 3. Original Policy document with receipt	Signature of the Assignee

Declaration to be signed by the Insured/ Claimant or by the Assignee (in the event of Insured's death).

I/WE HEREBY DECLARE and warrant the truth of the foregoing particulars in every respect. I / We agree that if / I / we have made, or if, shall make false or untrue statement, suppression or concealment, my/our right to compensation shall be forfeited.

I/WE ALSO HEREBY DECLARE that I am /we are accepting the amount in full discharge of your obligations under the policy to the Insured and / or his/her legal heirs and I/we will hold you indemnified in the event of any claim under this policy being made against you by any other person or persons.

Date:

Signature