

RAJRAJESWARI MAHILA KALYAN CLAIM FORM

The issue of this form is not to be taken as an Admission of liability.
POLICY NO._____ CLAIM NO.

SECTION I (TO BE FILLED IN FOR ALL CLAIMS)

1.	1. (a) Insured's Name		
	(b) Address:		
	(C) Age:		
	(d) Marital status:		
	(e) Name of Husband (if married):		
	(f) Occupation of husband:		
	(g) His Age:		
	(h) If not married, nam	e of the nominee:	
	(i) Age of the nominee		
	(j) Relationship with In	sured:	
2.	(a) Policy No		
		to	
3.	(a) Name of deceased/i	jured :	
•	(b) Particulars of Accide	nt:	
	(c) Date and time of A (d) Place of Accident:	cident:	
	(e) If removed to hosp	tal, name of the hospital:	
	 (b) Particulars of Accide (c) Date and time of Accident (d) Place of Accident: 	nt: cident:	



UNITED INDIA INSURANCE COMPANY LIMITED

4.	Do you have any other RMK policy? Yes/ No (a) If yes, Name of the company:		
	(b) Policy No.:		
	(d) Issued at:		
	(d) 155ded de		
5.	Claim in case of Divorce proceedings		
	(a) Legal proceedings initiated by:		
	(b) Name of the court:		
	(c) Date of filing the case:		
	(d) Date of decree:		
	(enclose certified copy of decree)		
	(e) Name of Advocate and his address:		
	(f) Legal expenses incurred:		
	(enclose Documentary evidence)		
6.	Details of Loss/Damage of household goods/personal effects (a) Date of accident:		
	(b) Cause of loss/damage:		
	(c) In case of burglary/theft, whether FIR has been lodged:		
	(d) Items lost/damaged Amount. Rs.		
	1		
	2		
	3		
	4		
	(e) Are you the sole owner of the property lost/damaged:		
	······································		
ve t	ne above name do hereby declare to the best of my/our knowledge and be		

I/w lief, warrant the truth of the foregoing statements in every respect and I/we agree that I/we have made, or in any further declaration which the company may required in respect of the said accident, shall make any false or fraudulent statements or any suppression or concealment the policy shall be void and all rights to recover thereunder in respect of past or future accident shall be forfeited.

Date _____

Signature of witness_____ (Signature of the Claimant)

SECTION II (TO BE FILLED IN BY HOSPITAL AUTHORITIES)

1. Name and address of the hospital:

- 2. Date of admission: _____
- 3. Date of death: _____
- 4. Cause of death:
- 5. Extent of injuries: ______6. Date of postmortem: ______

Date _____ Rubber Stamp of Hospital

Signature of the Competent Authority

CLAIM FORM - RAJRAJESWARI MAHILA KALYAN YOJNA