

Issuing office : _____

Date of Issue : _____

Claim No : _____

**PERSONAL ACCIDENT
DIS ABLEMENT
CLAIM FORM**

Royal Sundaram General Insurance Co. Limited

(Formerly known as Royal Sundaram Alliance Insurance Company Limited)

Corp. Office : Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR) Karapakkam, Chennai - 600097.

Regd. Office : 21, Patullos Road, Chennai - 600 002.

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

Please ensure that all questions are answered in Capital Letters using an ink pen

Policy Number

Certificate Number

Card Number /
Account Number

Name of the Bank

1. Insured/Insured Person

Name of the Insured/Insured Person

Name of the injured Person

Address for Correspondence

Telephone Daytime / Mobile Number

STD Code :

Telephone Evening

STD Code :

E-mail ID

2. Details of the accident

Date of the accident

 (DD/MM/YY)

Time of accident

 (AM/PM)

Place of accident

Nature and cause of accident

Was the accident reported to the Police?

Yes ☐

No ☐

If Yes please give the address of the Police Station

If No please give reason why

First Information Report Number & Date

3. Details of Injury

Nature of injury/disablement (if limb or eye is injured, please state whether right or left)

Period of disablement:

Confined to Bed

From

/

/

(DD/MM/YY)

To

/

/

(DD/MM/YY)

Confined to House

From

/

/

(DD/MM/YY)

To

/

/

(DD/MM/YY)

Name and Address of the attending physician (with Pin Code) & Phone No.

4. Other Insurance Details

Does the injured person have any other Personal Accident insurance?

Yes ☐

No ☐

If yes, please give the name and address of the Insurance company

Policy Number

Amount Insured for

5. DECLARATION

I hereby declare that the foregoing statements are made by myself and are true in all respects. I have not attempted to conceal from the Company anything with which it ought to be made acquainted. I agree that if I have made or in any further declaration that the Company may require, shall make any false or fraudulent statement or any suppression, concealment or untrue averment whatsoever, the Policy shall be void and my right to compensation forfeited. I am willing, if required, to make a Statutory Declaration before a Court of the truth of the whole of the Foregoing statement or any other statement I may make in connection with this claim.

Signature / thumb impression of the Insured

Date

/

/

(DD/MM/YY)

CERTIFICATE FROM THE EYE WITNESS TO THE ACCIDENT

I hereby certify that I was present when the accident occurred to Miss/Mrs/Mr. _____ on _____ (DD/MM/YY) in the manner stated overleaf. It was caused by _____

which was*/was not* his/her wilful act and he/she was*/was not* under the influence of intoxicating liquor / drugs at The time of accident.

*Strike out which is not applicable

Date	<div><div>/</div><div>/</div><div></div></div> <div>(DD/MM/YY)</div>	Signature / thumb impression of the eye witness	<div></div>
		Name	<div></div>
Place	<div></div>	Address	<div></div>

PLEASE CHECK THAT ALL QUESTIONS HAVE BEEN COMPLETED IN FULL & THE FORM SIGNED AND DATED. KINDLY SEND THE FOLLOWING DOCUMENTS

First Information Report - Photocopy duly attested by the issuing authority

Medical certificate forming part of the claim form

Admission / Discharge summary issued by hospital authority

English translation of vernacular documents

Medical bills and cash receipts in original

In case of temporary total disablement, leave certificate from the employer, if in service.

TO BE FILLED IN BY ATTENDING PHYSICIAN
MEDICAL CERTIFICATE FORMING PART OF PERSONAL ACCIDENT
DISABLEMENT CLAIM FORM

1. Name and Address of the injured person

2. Age of the injured person

3. Name & Address of the Hospital

4. IP / OP Number

5. Describe nature and extent of injury

6. Nature & cause of accident (so far as it is known to you)

7. Are you still attending on him/her?

☐ Yes

☐ No

8. Are you his/her usual Medical attendant?

☐ Yes

☐ No

9. If you have treated him/her for any previous
Illness or injury, please give details

10. Are his/her injuries

a. Solely due to the accident?

☐ Yes

☐ No

b. Traceable to any disease, infirmity Previous injuries or any
other cause?

☐ Yes

☐ No

If yes , please give details

11. Could the injuries, sustained in this accident be the sole cause of disablement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Was he / she to your knowledge under the influence of intoxicants or drugs at the time of accidents?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
or		
13. According to you, how long should the injured person be confined to bed / house as the direct and sole consequence of the injury sustained ?	From <input type="text" value="/ /"/> (DD/MM/YY)	To <input type="text" value="/ /"/> (DD/MM/YY)
14. During this period will the injured person be able to attend to his/her normal duties ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
a. If yes, form what date?	<input type="text" value="/ /"/> (DD/MM/YY)	
b. If not, Please state probable date of his / her being able to attend to his normal duties	<input type="text" value="/ /"/> (DD/MM/YY)	
15. Present Condition	<div style="border: 1px solid black; height: 60px;"></div>	
16. Nature of disablement (to be filled ONLY in case of permanent disablement)		
a. Permanent Total Disablement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Permanent Partial Disablement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes please specify percentage:	<input type="text"/>	
17. Any other remarks you wish to make	<div style="border: 1px solid black; height: 60px;"></div>	

I hereby certify that the injuries sustained by the person mentioned above are in accordance with the nature of the accident as described to me and that I treated him for the said injuries

Doctor's Name Qualifications Registration Address Phone No. E-mail	No Signature of the Doctor Date
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Additional Information :



ROYAL SUNDARAM INSURANCE
Sundaram Finance Group

Royal Sundaram General Insurance Co. Limited

Formerly known as Royal Sundaram Alliance Insurance Company Limited)

Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097. Registered Office: 21, Patullos Road, Chennai - 600 002.

Royal Sundaram IRDAI Registration No.102 | CIN:U67200TN2000PLC045611

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Insurance is the subject matter of solicitation.

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