CIN No. U66010RJ2006PLC029979
IRDA Registration Number: 137

Shriram General insurance Co. Ltd.
IN PARTNERSHIP WITH THE **Sanlam** GROUP
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Shri Group Personal Accident Insurance - Claim Form

The issue of this form is not to be taken as an admission of liability. Please ensure that all columns of the claim forms are filled in by the insured and no column remains unanswered. No claim will be admitted without a Medical Report as per format to be obtained at claimant's expense. Attach Separate Sheet if the space is not sufficient.

1.

Policy Number:		Claim Number:
Period of Insurance:		
Name of policy holder:		
Address:		
Contact Number:	Landline:-	Mobile:-
E-mail:		

2. Details of the Insured person in respect of whom the claim is made:

2.1. **Name of insured person:** _____

2.2. **Address:**_____

2.3. **Contact Number:**_____

3. In case death of insured person details of nominee

3.1. **Name of insured person:** _____

3.2. **Name of Nominee:** _____

3.3. **Relationship of nominee with insured person:** _____

3.4. **Address:** _____

3.5. **Contact Number:** _____

4. Details of Accident:

4.1. **Date of Accident:** _____

4.2. **Time of Accident:** _____

4.3. **Place of Accident** _____

4.4. **Please provide brief detail of accident**_____

_____

5. Name and Address of Hospital/Nursing home where the injured is treated

_____

_____

6. Have the police been informed about the accident

Yes: _____ No: _____

If yes, please give details: FIR No. _____ Name of Police Station _____

7. Was the injured person under the influence of liquor/drugs at time of accident

Yes: _____ No: _____

8. Witness of accident

Name and contact details including Phone number

8.1. _____

8.2. _____

9. Where the Injured person can be contacted

_____

10. Please provide details of the claim sections wise:-

Section	Sum Insured	Disability %, if any	Claim Amount
Accidental Death & Disappearance			
Transportation of Mortal Remains			
Children's Education Benefit			
Permanent Total Disability			
Permanent Partial Disability			
Temporary Total Disability			
Hospital Confinement Allowance			
Accidental Hospitalisation Cover			
Medical Expenses Reimbursement			
Modification of Accomodation & vehicle			

Please Mention N/A Wherever is not applicable.

Declaration
(To be given by the Claimant)

I hereby to the best of my knowledge and belief, warrant the truth of the above details in every respect. I agree that if we have made already or if I make in any of my further statements in respect of the said incident or any false or fraudulent declarations or suppress or conceal any material fact, the Policy shall be void and all rights of compensation in respect the present or future claim shall be forfeited.

Place: _____

Date:__.__.____ Signature of Claimant / Insured

ATTENDING PHYSICIAN'S STATEMENT

1.	Name of Injured Person	
2.	Age	
3.	Address	
4.	Nature of the Accident and Details of Injuries Sustained	
5.	Does the Cause of Accident as stated by the Claimant tally with the Injuries noticed by you?	
6.	Are the injuries solely due to the accident or traceable to any previous injuries/ disease/ infirmities?	
7.	Was the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition?	
8.	Was the Claimant hospitalized? If so for what period?	
9.	Was he under the influence of intoxicants or drugs at the time of accident	
10.	Are you his usual medical Attendant? If you have treated him for any previous illness or injury, please give details	
11.	Have other Doctors been in Attendance or Consultation? If yes, Please give details	
12.	Has this accident been reported to the Police Authorities? If yes, Case No: Police Station :	
13.	**Details about disablement due to accident**	

Doctor's Signature:	Reg. No:
Doctors Name:	Date :
Address and Phone No:	