United India Insurance Company Limited
Corporate Identity Number: U93090TN1938GOI000108
Registered Office: 24 Whites Road, Chennai – 600014
IRDAI REG NO.545

Janata Personal Accident Insurance
Claim Form

(Without prejudice)

Important Instructions (Please read the instructions below carefully before filling out this form)

- Issuance of this form or registration of claim does not constitute admission of liability.
- Please provide all the information sought in this Claim Form and any additional relevant information fully and accurately.
- All questions must be answered completely and accurately answered. Write "Not Applicable" or "N/A" wherever the question does not apply.
- The duly completed and signed Treating Doctor's Certificate / Medical Report (Annexure 1) is a mandatory document and must be submitted with this form.

I. CLAIM INTIMATION DETAILS			
Claim Intimation No. *(if already intimated)*			
Master Policy No.		Certificate No. *(if issued)*	

II. POLICYHOLDER / GROUP ADMINISTRATOR DETAILS			
Name of Policyholder / Group Organiser			
Address			
Contact Number		Email	
Name of Contact Person (if any)			

III. DETAILS OF INSURED PERSON (INJURED / DECEASED)			
Full Name of Insured Person			
Date of birth	DD/MM/YYYY	Gender	☐ Male ☐ Female ☐ Other
Occupation			
Employee ID / Membership No. (if applicable)			
Address			
Photo ID Proof Type & Number (Aadhaar / PAN / Voter ID / Passport etc.)			
Nominee Name (as per policy schedule)			
Relationship			

IV. NATURE OF CLAIM (Please tick the applicable benefit)

☐ **Accidental Death** - 100% of Capital Sum Insured
☐ **Permanent Total Disablement (PTD) –** 100% of Capital Sum Insured
☐ **Permanent Total Disablement (PTD) –** 50% of Capital Sum Insured

(Only one of the above can be claimed for the same injury as per policy condition)

V. ACCIDENT DETAILS			
Date of Accident	DD/MM/YYYY	Time	: AM/PM
Place of Accident			
Detailed description of how the accident occurred			
Nature & extent of injuries sustained			
If Permanent Disability, exact nature of disability *(must be certified by specialist)*			
Was the Insured Person under the influence of alcohol / intoxicants at the time of accident?	☐ Yes ☐ No		
Was the accident related to any excluded activity in the policy *(adventure sports, racing, aviation other than fare-paying passenger, war, suicide, criminal act etc.)?*	☐ Yes ☐ No		
VI. POLICE & MEDICO-LEGAL INFORMATION			
Was the accident reported to Police?	☐ Yes ☐ No		
If Yes – FIR / NCR No.			
Police Station & address			
Is / Was the case treated as a Medico-Legal Case (MLC)?	☐ Yes ☐ No		
If Yes – MLC No.			
VII. HOSPITALISATION & TREATMENT DETAILS (if applicable)			
Name of Hospital			
Address of Hospital			
Date of Admission	DD/MM/YYYY	Date of Discharge	DD/MM/YYYY
Name(s) of Treating Doctor(s)			
VIII. CLAIMANT / PERSON ENTITLED TO RECEIVE CLAIM PAYMENT (If the Insured Person is alive and claiming himself/herself → tick the first option only. In all other cases, tick the correct category and fill details)			
Person entitled to receive claim payment	☐ Insured person (self) ☐ Nominee (as per policy schedule) ☐ Legal Heir (if no subsisting nominee) ☐ Appointee (where nominee is a minor) ☐ Assignee (in case the benefit has been absolutely assigned)		
Full Name			
Relationship with Insured Person			
Address			
Contact No.		Email	

IX. BANK DETAILS FOR CLAIM PAYMENT (NEFT MANDATORY)

Account Holder Name *(as per bank records)*			
Bank Name		Branch	
Account Number		IFSC Code	
PAN of Payee			

(Attach cancelled cheque or bank passbook copy)

X. LIST OF DOCUMENTS ATTACHED (Please tick)

For Accidental Death Claims:

- ☐ Policy Schedule / Certificate of Insurance
- ☐ Duly completed & signed Claim Form
- ☐ Death Certificate
- ☐ Post-Mortem Report (with viscera/chemical analysis if done)
- ☐ FIR / Panchnama Report
- ☐ Medico-Legal Certificate (MLC)
- ☐ Medical records / treatment papers (if any)
- ☐ Photo ID & Address proof of deceased & nominee/legal heirs
- ☐ Legal Heirship Certificate / Succession Certificate (if no nominee) + Indemnity Bond
- ☐ NEFT Mandate Form + Cancelled Cheque
- ☐ Any other document requested by the Company

For Permanent Total Disable/Disability Claims:

- ☐ Policy Schedule / Certificate of Insurance
- ☐ Duly completed & signed Claim Form
- ☐ FIR / Panchnama / MLC (wherever applicable)
- ☐ All medical records, investigation reports, discharge summary
- ☐ Disability Certificate from treating specialist clearly stating the exact disability
- ☐ Photographs of the Insured Person clearly showing the disability (face visible)
- ☐ Photo ID & Address proof of Insured Person
- ☐ NEFT Mandate Form + Cancelled Cheque
- ☐ Any other document requested by the Company

XI. DECLARATION & CONSENT

1. I/We hereby declare that the information furnished above is true and correct to the best of my/our knowledge and belief.
2. I/We authorise United India Insurance Co. Ltd. to seek any medical information / records from any hospital / doctor who has attended to the Insured Person.
3. I/We also authorise the Company to (or its representatives) to examine the Insured Person whenever required.

Place: _____ Date: DD/MM/YYYY _____

Signature / Thumb Impression of
Claimant /Nominee / Legal Heir

For Office Use only

Claim Registered On:		Claim No.	
Documents Pending *(if any)*			

ANNEXURE 1 : TREATING DOCTOR'S CERTIFICATE / MEDICAL REPORT

TO BE FILLED BY TREATING DOCTOR *(To be filled only by the Registered Medical Practitioner who treated the patient)*				
Name of the Patient (Injured/Deceased)				
Gender	☐ Male ☐ Female ☐ Other		Date of Birth	DD/MM/YYYY
Date & Time of Accident				
Date & Time of First Consultation				
Date of Admission (if hospitalized)	DD/MM/YYYY		Date of Discharge / Death	DD/MM/YYYY
Nature of the Accident/Incident and details of injuries sustained				
Cause of Accident/Incident				
In your opinion, are the injuries / disability / death	1	Solely due to Accident/Incident	☐ Yes ☐ No	
	2	Traceable to any disease	☐ Yes ☐ No	
		(If Yes, specify)		
	3	Traceable to any previous injury	☐ Yes ☐ No	
		(If Yes, specify)		
Was the patient under the influence of alcohol, drugs, or intoxicants at the time of accident?	☐ Yes ☐ No			

Is the patient currently suffering from a Total and Irrecoverable Loss of any of the following? (Please mark all that apply)			
1. Both hands?	☐ Yes ☐ No	4. One hand/foot and one eye?	☐ Yes ☐ No
2. Both feet?	☐ Yes ☐ No	5. Sight of both eyes?	☐ Yes ☐ No
3. One hand and one foot?	☐ Yes ☐ No	6. Speech and hearing of both ears?	☐ Yes ☐ No

Is the patient suffering from a Total and Irrecoverable Loss of any of the following? (Please mark all that apply)			
1. One hand/foot?	☐ Yes ☐ No	2. Sight of an eye?	☐ Yes ☐ No

Any other Permanent Total Disability (not listed above) that permanently prevents the patient from doing any job or occupation for earnings?	☐ Yes ☐ No
Is the disablement Permanent & Total in nature and likely to continue for the remainder of the patient's life?	☐ Yes ☐ No ☐ Not applicable If No, expected period of recovery: _____
If the patient has expired, was death caused solely and directly due to the accident and independent of any other cause?	☐ Yes ☐ No ☐ Not applicable If No, please specify contributing factors: _____
Any other remarks / observations relevant to the claim	

Name of Treating Doctor: _____ **Qualification**: _____

Registration No.: _____ **Contact No.**: _____ **Email**: _____

Hospital / Clinic Name & Address: _____

Date: _____ Place: _____ Signature of Treating Doctor & Hospital Seal / Stamp