The New India Assurance Company Limited

Regd & Head Office: New India Assurance Building, 87, M.G. Road, Fort, Mumbai - 400 001.

Policy Issuing Office : Bandra Divisional Office 142300
C-6,NCL Business Premises, 1st Floor, Bandra-Kurla Complex, Mumbai 400051.
Contact no.(022) 26591702(Direct) / 26590156

RuPay CARDHOLDER'S PERSONAL ACCIDENT INSURANCE CLAIM FORM

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

POLICY NUMBER	
RuPay CARD TYPE	PREMIUM/NON-PREMIUM
RuPay CARD NUMBER	
D/o issue & last D/o swapping	
CLAIM NO.	

TO BE COMPLETED BY THE INSURED / CLAIMANT

1) a. NAME,ADD & CONTACT NO.OF MEMBER BANK :
   b. NAME OF INSURED PERSON :
   c. ADDRESS IN FULL :
   d. PROFESSION OR OCCUPATION :
   e. AGE AT LAST BIRTHDAY :

2) BRIEF DISCRIPTION OF ACCIDENT :

4) PARTICULARS OF ACCIDENT
   a.i) DATE OF ACCIDENT :
   a.ii) TIME OF ACCIDENT :
   a.iii) PLACE OF ACCIDENT :
   a.iv) NAME & ADDRESS OF WITNESS :

5) NATURE OF CLAIM : **[DEATH / PERMANENT DISABLEMENT**]

6) NATURE OF DISABLEMENT :
   [SPECIFY DISABILITY AS PER COVERAGE]

   PRESENT STATE OF INCAPACITY :

7) NAME AND ADDRESS OF SURGEON IN ATTENDANCE :

8	a.	WHERE AND WHEN CAN A MEDICAL OFFICER OF THE COMPANY VISIT YOU, IF NECESSARY ?	
	b.	NAME OF NEAREST RAILWAY STATION AND DISTANCE THEREFROM	
9	a.	ARE YOU HOLDER OF ANY OTHER RuPay CARD, IF YES THEN NO. OF RuPay CARD/S HELD	
	b.	IF SO, STATE NAME/S OF MEMBER BANK	

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

WITNESS		SIGNATURE OF INSURED	
SIGNATURE		DATE	
NAME			
ADDRESS			

CERTIFICATE TO BE FILLED UP AND SIGNED BY AN EYE WITNESS TO THE ACCIDENT

I hereby certify that I was present when the Accident occurred to Mr./ Ms._____ on the _____ day of _____20 __ in the manner stated by him/her over leaf, that it was caused by _____which * was / was not his/her willful act and that he /she * was / was not under the influence of intoxicating liquor at the time.

*Strike out which is not applicable

SIGNATURE & DATE	
NAME	
ADDRESS	
OCCUPATION	

MEDICAL CERTIFICATE

Claims must be supported by medical evidence furnished by the Insured and at his expense.

1.	(a)	Name of Claimant	(b) Sex	(c) Age
2.	(a)	Nature and cause of accident	:	
	(b)	If injury to eye or limb, whether one(state left or right) or both	:	
	(c)	Whether the appearance of the injuries are Consistent with the description the accident	:	
3.		Date on which you first attended Claimant for this injury	:	
4.		Has the Claimant been disabled totally or partially ?	:	
5.		If partial disability, please specify %age	:	
6.		Is the Claimant suffering from any disease or illness apart from the Injury? Is the claimant suffering from any illness/symptoms which may tend to Retard Recovery ? If so, give particulars	:	

Having personally examined the above named Insured, I certify that the above statements are correct and that the insured person is necessarily disabled by the accident referred to

Signature : _____

Name & Qualification : _____

Address : _____

Date : _____