Universal Sompo General Insurance Co. Ltd.

(A joint venture between Allahabad Bank, Sompo Japan Insurance Inc., Indian Overseas Bank, Karnataka Bank and Dabur Investments.)

Regd. Office: 201-208, Crystal Plaza, Opp. Infiniti Mall, Link Road, Andheri (West), Mumbai - 400 058.

AAPAT SURAKSHA BIMA CLAIM FORM

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

a) Claim form is to be filled in capital letter & signed by the insured/claimant.
b) Please do not leave any column unanswered.
c) Please read carefully the attached list of documents required to speed up processing of your claim.
d) If there is insufficient space, kindly use a separate sheet which can be attached to this form.

Claim No.

A. INSURED

	First Name	Middle Name	Last Name
Name of the Insured			
Name of the Claimant			

Relationship with Insured ___ Designation (If applicable) ___

Date of Birth ___ Sex ☐ Male ☐ Female Email ID ___

Communication Address ___

City/Taluka ___ District ___ State ___

Pin Code ___ STD code ___ Phone No. ___ Mobile No. ___

B. DETAILS OF POLICY

Policy No. ___ / ___ / ___ / ___

Period of insurance from ___ to ___ Sum Insured ___

C. DETAILS OF OTHER POLICIES

Have you been insured under any Personal Accident / Critical Illness Policy of any other insurance companies? ☐ Yes ☐ No
If "Yes", please enclose photocopies of all previous policies.

Date of commencement of very first insurance for the Beneficiary with continuous insurance coverage? from ___ to ___

D. DETAILS OF INCIDENCE

Nature of Disease /Illness / Injury ___

Cause of Disease /Illness / Injury ___

Date of incidence ___ Time of incidence ___ : ___ AM/PM.

Place of incidence ___

Incidence Reported to ___

Are there any witness to incidence ☐ Yes ☐ No

Names and Address of witnesses ___

E. DETAILS OF HOSPITAL

Was the insured person moved to hospital immediately after the incidence ☐ Yes ☐ No

If "Yes", please fill in the following

Date of admission ☐☐☐☐☐☐ Time of admission ☐☐ : ☐☐ AM/PM.

Date of discharge ☐☐☐☐☐☐ Time of discharge ☐☐ : ☐☐ AM/PM.

Name of the Hospital

Address

City/Taluka District State

Pin Code STD code Phone No. Mobile No.

Particulars of treatment

F. DOCTOR'S DECLARTION

I hereby certify that was treated by me on

for which first incurred on and is related to the incident mentioned above.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

He / She is suffering from,

Paralytic Stroke	☐ Yes ☐ No	Coronary Artery Disease	☐ Yes ☐ No
End stage Renal failure	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Major Organ Transplant	☐ Yes ☐ No		

If "Yes", please specify, ☐ Kidney ☐ Lung ☐ Pancreas ☐ Bone Marrow

☐ Any Other(If "Yes",please specify) _____

Has the incidence resulted into;

Loss of sight of one eye	☐ Yes ☐ No	Loss of sight of both eyes	☐ Yes ☐ No
Loss of foot	☐ Yes ☐ No	Loss of both feet	☐ Yes ☐ No
Loss of hand	☐ Yes ☐ No	Loss of both hands	☐ Yes ☐ No

Any other Details

The ailment was caused by / in any way associated with the below mentioned conditions;

Pregnancy or childbirth	☐ Yes ☐ No	Intentional Self Injury	☐ Yes ☐ No
War and allied peril	☐ Yes ☐ No	Nuclear Perils	☐ Yes ☐ No
On duty with any armed forces	☐ Yes ☐ No	Mental disease	☐ Yes ☐ No
Intentional self injury	☐ Yes ☐ No	Use of Intoxicating drugs ,	☐ Yes ☐ No
Smoking or alcohol	☐ Yes ☐ No	HIV, AIDS	☐ Yes ☐ No
Venereal disease or sexually transmitted disease	☐ Yes ☐ No		

Name of the treating Medical Practitioner First Name Middle Name Last Name

Registration No. Qualification

Date:

Place:

Stamp and Signature of the Medical practitioner

G. DETAILS OF CURRENT CLAIMED AMOUNT

	Description	Amount (Rs.)
(A)	Death	
(B)	Permanent Total Disability	
(C)	Permanent Partial Disability	
(D)	Critical Illness	
(E)	Any other (1)	
(J)	Any other (2)	
TOTAL AMOUNT CLAIMED		

H. ENCLOSURES

- ☐ Claim form duly signed
- ☐ Policy copy
- ☐ Claim intimation
- ☐ FIR/ MLC copy
- ☐ Death certificate
- ☐ Post mortem report
- ☐ Inquest / Coroner's report
- ☐ Final police report
- ☐ Disability Certificate
- ☐ Investigation reports
- ☐ Medical certificate
- ☐ Nominee certificate
- ☐ Employer Certificate
- ☐ Photograph of the injured with reflecting disablement
- ☐ Any other documents

If "Yes", please specify

Any other information You wish to state

I. EMPLOYER'S DECLARATION

This is to certify that Mr./Ms ____________, working as ________, permanent Employee Id No. ________ covered under Aapat Suraksha Bima Policy No. ____ / ________ / ___ / ___ was on leave for the period ________ to ________ Sum Insured. ________ The total numbers of employees on permanent rolls as on the date of accident were ____
The above information is true to the best of my knowledge and we agree to provide any further information that may be required.

Date: ________ Signature of Authorized signatory:

Place: ________ Name of the Authorized signatory ________

Company Seal

I. INSURED'S / CLAIMANT'S DECLARATION

I hereby warrant the truth of foregoing statement and sincerely declare that I have not suppressed or concealed any information that is material to this claim. I understand that false declaration/s may result in USGI being able to refuse to pay the claim.

The receipt of this claim form/ other supporting / related document does not constitute or be deemed to constitute an agreement by the USGI of the claim and the USGI reserves the right to process or reject or require further / additional information in respect of the claim.

Date: ________ Signature of Claimant:

Place: ________ Name of the Claimant: ________

PTO

J. TO BE COMPLETED BY NOMINEE IN THE EVENT OF INSURED'S DEATH

First Name | Middle Name | Last Name

Name of the Nominee

Relationship with Claimant

Date of Birth Sex ☐ Male ☐ Female Email ID

Communication

Address

City/Taluka District State

Pin Code STD code Phone No. Mobile No.

If nominee is minor, kindly provide the Legal Guardian details

First Name | Middle Name | Last Name

Name of the Legal Guardian

Address

City/Taluka District State

Pin Code STD code Phone No. Mobile No.

Date of Birth Sex ☐ Male ☐ Female Email ID

I/We hereby declare and warrant the truth of the foregoing particulars in every respect. I /We agree that if I/We have made or shall make false or untrue statement, suppression or concealment, my/our right to compensation shall be forfeited. I/We also hereby declare that I am/we are accepting the amount in full discharge of your obligations under the policy to the Insured Person and /or his/her legal heirs. I/we will hold you indemnified in the event of any claim under this policy being made against you by any other person or persons.

Date:

Signature of Nominee / Legal Guardian:

Place:

Name of the Nominee / Legal Guardian