Personal Accident Insurance Claim Statement

1. Policyholder Details

Full Name : _____

Policy Number : _____

Address : _____

Contact Number : _____

Email : _____

2. Accident Details

Date of Accident : _____

Time of Accident : _____

Location : _____

Brief Description of Accident : _____

Nature of Injury : _____

Was the Accident Reported to Police? : [ ] Yes [ ] No

If Yes, Police Report Number : _____

3. Hospital / Doctor Details

Name of Hospital/Clinic : _____

Date of Admission : _____

Date of Discharge : _____

Attending Doctor : _____

4. Details of Claim

Type of Claim : [ ] Medical Expenses [ ] Disablement [ ] Death

Amount Claimed : _____

5. Bank Account Details (for claim payment)

Bank Name : _____

Account Number : _____

Account Holder Name : _____

IFSC / Branch Code : _____

6. Declaration

I hereby declare that the above information is true and complete to the best of my knowledge. I authorize the insurer to obtain further information from any hospital or medical practitioner as required for processing this claim.

Signature : _____

Date : _____

Important Notes:

- Ensure all fields are completed accurately to avoid delays in claim processing.
- Attach all supporting documents such as medical invoices, police reports, and hospital discharge summaries.
- Incorrect or false information may result in claim rejection.
- This form must be signed by the policyholder or a legal representative.
- Claims must be submitted within the stipulated period as mentioned in your policy wording.