



# The New India Assurance Company Limited

(Regd. & Head Office : New India Assurance Bldg., 87, Mahatma Gandhi Road, Fort, Mumbai - 400 001.)

***The issue of this form is not to be taken as an admission of Liability***

## CLAIM FORM FOR

### NEW INDIA PENSION PROTECT PERSONAL ACCIDENT POLICY

(UIN No: NIAPAIP23064V012223)

Policy No. \_\_\_\_\_

Branch /Unit \_\_\_\_\_

Claim No. \_\_\_\_\_

### TO BE COMPLETED BY THE CLAIMANT

1. (a) Name of the Insured [in full] \_\_\_\_\_  
(b) Address in full \_\_\_\_\_  
(c) Name of organization from where Retired \_\_\_\_\_  
(d) Age at last birthday \_\_\_\_\_  
(e) Place and Date of Retirement \_\_\_\_\_  
(f) Type of pension scheme (Old/NPS) \_\_\_\_\_
2. (a) Policy No. \_\_\_\_\_  
(b) Sum Insured \_\_\_\_\_  
(c) Policy Period \_\_\_\_\_

3	(a) Date of the accident?	
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	(b) Time of accident? (c) Where it happened? (d) Name and address of witness	
4.	How did the accident occur ?	
5.	Nature of injury received (If to limb or eye state whether right or left)	
6.	(a) Nature of disablement (b) Extent of disablement Confined to bed Confined to house (c) Present state of incapacity	[from _____ To _____] [from _____ To _____]
7.	Name and address of treating doctor/surgeon and medical institution	
8.	(a) Are you insured in any other office or offices granting compensation for accident (b) If so state name and address of company or companies and amount of insurance	

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 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 a connection with this claim.

Witness:	Nominee
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Name _____	Name _____
Date _____	Date _____
Address _____	Address _____

**CERTIFIED 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. \_\_\_\_\_ On \_\_\_\_\_ the  
 \_\_\_\_\_ day of \_\_\_\_\_ 20  
 \_\_\_\_ in the manner stated by him over leaf, that it was caused by  
 \_\_\_\_\_ which \* was / was not his willful act and that he \*  
 was/was not under the influence of intoxicating liquor at the time

_____	Signature
_____	Address
* Strike out which is not applicable	Occupation
_____	Date
_____	

Claims must be Supported by medical Evidence furnished by the Insured and at his expense.

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1. (a) Name of Claimant (b) Sex (c) Age

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2. (b) Nature and cause of accident  
(b) If to eye or limb, state left or right  
(c) Whether the appearance of the Injuries are consistent with the account given of the accident.
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3. Date on which you first attended Claimant for this injury

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4. Has Claimant been totally prevented from attending to any portion of his business ? If so how long ?

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1. Is Claimant suffering from any disease or illness apart From his injury and is there any illness by circumstances Which may tend to retard recovery? If so, give particulars?

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2. Present Condition

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7. How long from the happening of the Accident do you consider Total disablement will last ?

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name &

Qualification \_\_\_\_\_  
Address \_\_\_\_\_

\_\_\_\_\_  
Date \_\_\_\_\_

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**REMARKS FOR EXTRA DETAILS**

**ECS Details of the Insured**

1	Name of the Insured (as appearing in the Bank Account)	
2	Bank Name	
3	Branch and address	
4	Bank Account No.	
5	Bank Account Type	
6	IFSC Code	
7	MICR Code	