दि ऑरिएण्ट्ल इन्श्योरेन्स कंपनी लिमिटेड
प्रधान कार्यलय: ऑरिएण्ट्ल हाउस, पो.बा.नं. ७०८७
ए.२५/२७, आसफ़ अली रोड, नई दिल्ली - ११० ००२.

THE ORIENTAL INSURANCE COMPANY LIMITED
Head Office: ORIENTAL HOUSE, P.B.No.7037,
A-25/27, Asaf Ali Road, New Delhi - 110 012.

STUDENT SAFETY ACCIDENT INSURANCE CLAIM FORM

The issue of this form is not to be construed as an admission of liability

Claim No. _____ **Policy No.:** _____

SECTION: 1 (To be completed in respect of all claims)	Policy No.:
1 (a) Insured's Name	(a) _____
(b) Address	(b) _____
(C) Age	(C) _____
2 (a) Policy No.	(a) _____
(b) Period of Inusrance	(b) _____
(C) Issuing Office	(C) _____
3 (a) When did the accident occur?	(a) Date Time Place Whether reported to the police _____a.m./p.m. _____ Yes/No
(b) Details	(b) _____ _____
4 (a) Were you removed to hospital immediately after the accident?	(a) Yes/No
(b) If yes, Name and Address of the hospital	(b) _____
5 (a) Have you taken any other Janata Personal Accident Policy?	(a) Yes/No
If yes, pleases state	(i) _____
(i) Name of the Company	(ii) _____
(ii) Address of the Company	(iii) _____
(iii) Policy No.	(b) Yes/No
(iv) Period of Insurance	
(b) Are you entitled to recover medical/ hospitalisation expenses under any other medioal / hospitalisation scheme?	
If yes (i) Nature of the Scheme	(i) _____
(ii) Amount paid or payable	(ii) _____
SECTION: II (To be completed by hospital authorities)	
	As in-patient / Outpatient / Emergency Case
1 Name and Address of the Hospital	1 _____ _____ _____
2 Date of Admission	2 _____
3 Date of Discharge	3 _____
4 (a) Nature of injury	4 a) _____
(b) Particulars of treatment	b) _____

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Has the accident resulted into Permanent total irrecoverable loss or loss of use of hand/s or foot/feet or eye/s or permanent disability of any other type which may prevent the insured from engaging in or being occupied with or giving attention to any employment or occupation whatsover? If yes, please give details	

Hospital Expenses (Please attach original bills)

Rubber Stamp of Hospital

Signature of the Competent authority of Hospital/ Nursing Home

Name : _____

Designation: _____

SECTION: III (To completed by nominee in the event of insured's death)

Details of Nominee

Full Name _____

Address _____

_____

Age _____

Relationship with the deceased _____

_____

Signature of the Nominee

Please attach the following documents:

1 Original Death Certificate
2 Post-Mortem Report
3 Original Poloicy
4 Police Panchanama
5 FIR

Declaration to be signed by the Insured or by the Nominee (in the event of death of insured)

HERE BY DECLARE and warrant the truth of the foregoing particulars in every respect, I have neither concealed nor impressed any facts. I agree that if I have made or shall make false or untrue statement or conceal any material information, rights for compensation shall be forefeited.

ALSO HERE BY DECLARE that I am accepting the amount of Rs…… discharge of your obligations under the policy to the insured and / or his / her legal heirs and I will hold you indemnified the event of any claim under this policy being made against you by any other person or persons.

Signature of Insured / Nominee ……..

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