

UNITED INDIA INSURANCE COMPANY LTD Regd. & Head Office: 24, WHITES ROAD, CHENNAI-600 014) BRANCH / DIVISIONAL OFFICE...... UNI-STUDY CARE GROUP INSURANCE CLAIM FORM

The issue of this form does not constitute admission of liability.

Please return this form duly completed together with relevant reports / Bills / Certificates etc.,

Policy No: Claim No:

1.	(a) Name of the College / Institution(b) Address	(a) (b)
	c) Name of the claimantd) Address	
3	Particular of injured person: (a) Name in full (b) Last full postal address (c) Last occupation (d) Age at the time of accident Details of accident: a) When did the accident happen(Give date and exact time) b) Where did the accident happen c) Give full description of the accident, its cause and injuries sustained d) State date, time and place of death e) Give names and addresses of two persons who witnessed the accident. f) Was the injured person free from infirmity at the time of accident? If not give particulars. g) Was the injured person under the influence of drugs or drink at the time of accident? h) Name and address of the hospital where the injured person was treated after the accident.	(a) (b) (c) (d)

4	Hospitalisation details:	
	a) Name of the student (in respect of	a)
	whom claim is made)	
	b) Present completed age	b)
	c) Nature of Disease / Illness contracted	(c)
	or injury sustained	d)
	d) Date of injury sustained or disease/	
	illness first detected	e)
	e) Name and address of the Hospital /	
	Nursing Home	f)
	f) Date of Admission	
	g) Date of Discharge	g)
	h) Details of expenses	h)
	(supporting Bills / Receipts / Cash	i)
	Memos along with discharge summary	
	are to be enclosed to this claim form)	
5	a) a) Give details of baggage lost with	(a)
	cause and value (attach separate	
	list if necessary)	(b)
	b) b) Where and how was the baggage	
	lost? Give full details.	
	c) When and to which police station	
	was it reported (please attach copy of	
	FIR)	
	TT 4 T 4 . 1 . 1 . 1 . 1	
6	Has the Insured sustained similar loss/es	
	prior to this loss? If yes, give details of	
	insurer and claim amount.	
7	Amount of loss Claimed	Rs
/	Amount of loss Claimed	KS
Ь		

I/ we declare that the above information furnished are correct in all aspects.

Date:	
Place:	Signature of student / claimant

Signature of principal / head of institution

Sheet1

UNITED INDIA INSURANCE CO. LTD.
DIVISIONAL OFFICE-I, KRISHNA COMPLEX, I ST FOOR KUTCHERY CHOWK, RAIPUR
PH. 0771-4034065, 2226461, 2228403

NAME	OF	INSU	IRED:

CLAIM NO.

CLASS OF BUSINESS: CL FOR THE PERIOD:

BIFURCATION OF CLAIM AMOUNT

S.No.	Bill No.	Bill Date	Bill from- Shop/Hospital/	Prescription	AMOUNT	Contact No.of prescrip
			Diagnostics Centre	No. & Date		tion issued centre
			- William			
				10-11-11-11-11-11-11-11-11-11-11-11-11-1		1000
			31 24 1			7,47
					7 (4	
				The state of the s	2007	
						1 = x N
_						
			-27			
				1 2 2		
			- 12 m			
					50	
				7-31		· gland
				100	- W	
				The state of the s		
						2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
					27 (6)	
				Markey 1991		
			2	10.7		
				1		
				A CONTRACTOR OF THE PROPERTY O		
				GR. TOTAL RS.		

Da	+0	
Da	ILE	

Name & Signature of the Insured/Claimaint Mbile No.