



**Royal Sundaram**

**PERSONAL ACCIDENT  
DISABLEMENT  
CLAIM FORM**

<b>FOR OFFICE USE ONLY</b>	
Issuing office :	_____
Date of Issue :	_____
Claim No :	_____

**ROYAL SUNDARAM ALLIANCE INSURANCE COMPANY LIMITED**  
46, Whites Road, Chennai-600 014. Telephone : 044-28517387 - 7391 Fax: 044-2851 5500  
E-mail : customer.services@royalsundaram.in

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

Please ensure that all questions are answered in Capital Letters using an ink pen

Policy Number	<input type="text"/>	Certificate Number	<input type="text"/>
Card Number / Account Number	<input type="text"/>	Name of the Bank	<input type="text"/>

**1. Insured/Insured Person**

Name of the Insured/Insured Person	<input type="text"/>
Name of the injured Person	<input type="text"/>
Address for Correspondence	<input type="text"/>
Telephone Daytime / Mobile Number	STD Code : <input type="text"/>
Telephone Evening	STD Code : <input type="text"/>
E-mail ID	<input type="text"/>

**2. Details of the accident**

Date of the accident	<input type="text"/>	(DD/MM/YY)
Time of accident	<input type="text"/>	(AM/PM)
Place of accident	<input type="text"/>	
Nature and cause of accident	<input type="text"/>	
Was the accident reported to the Police?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes please give the address of the Police Station	<input type="text"/>	
If No please give reason why	<input type="text"/>	
First Information Report Number & Date	<input type="text"/>	

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■ **3. Details of Injury**

Nature of injury/disablement (if limb or eye is injured, please state whether right or left)

Period of disablement:

Confined to Bed

From  To   
(DD/MM/YY) (DD/MM/YY)

Confined to House

From  To   
(DD/MM/YY) (DD/MM/YY)

Name and Address of the attending physician (with Pin Code) & Phone No.

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■ **4. Other Insurance Details**

Does the injured person have any other Personal Accident insurance?

Yes  No

If yes, please give the name and address of the Insurance company

Policy Number

Amount Insured for

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■ **5. DECLARATION**

I hereby declare that the foregoing statements are made by myself and are true in all respects. I have not attempted to conceal from the Company anything with which it ought to be made acquainted. I agree that if I have made or in any further declaration that the Company may require, shall make any false or fraudulent statement or any suppression, concealment or untrue averment whatsoever, the Policy shall be void and my right to compensation forfeited. I am willing, if required, to make a Statutory Declaration before a Court of the truth of the whole of the foregoing statement or any other statement I may make in connection with this claim.

Signature / thumb impression of the Insured

Date

/ /  
(DD/MM/YY)

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**CERTIFICATE FROM THE EYE WITNESS TO THE ACCIDENT**

I hereby certify that I was present when the accident occurred to Miss/Mrs/Mr. \_\_\_\_\_ on \_\_\_\_\_ (DD/MM/YY) in the manner stated overleaf. It was caused by \_\_\_\_\_

which was\*/was not\* his/her wilful act and he/she was\*/was not\* under the influence of intoxicating liquor / drugs at the time of accident.

\*Strike out which is not applicable

Date :	/ /	Signature / thumb impression of the eye witness	
	(DD/MM/YY)		
		Name	
Place		Address	

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**PLEASE CHECK THAT ALL QUESTIONS HAVE BEEN COMPLETED IN FULL & THE FORM SIGNED AND DATED.  
KINDLY SEND THE FOLLOWING DOCUMENTS**

First Information Report - Photocopy duly attested by the issuing authority

Medical certificate forming part of the claim form

Admission / Discharge summary issued by hospital authority

English translation of vernacular documents

Medical bills and cash receipts in original

In case of temporary total disablement, leave certificate from the employer, if in service.

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**TO BE FILLED IN BY ATTENDING PHYSICIAN**  
**MEDICAL CERTIFICATE FORMING PART OF PERSONAL ACCIDENT**  
**DISABLEMENT CLAIM FORM**

1. Name and Address of the injured person

2. Age of the injured person

3. Name & Address of the Hospital

4. IP / OP Number

5. Describe nature and extent of injury

6. Nature & cause of accident (so far as it is known to you)

7. Are you still attending on him/her?

Yes

No

8. Are you his/her usual Medical attendant?

Yes

No

9. If you have treated him/her for any previous illness or injury, please give details

10. Are his/her injuries-

a. Solely due to the accident?

Yes

No

b. Traceable to any disease, infirmity previous injuries or any other cause?

Yes

No

If yes , please give details

11. Could the injuries, sustained in this accident be the sole cause of disablement

Yes

No

12. Was he / she to your knowledge under the influence of intoxicants or drugs at the time of accidents?

Yes

No

13. According to you, how long should the injured person be confined to bed / house as the direct and sole consequence of the injury sustained ?

From  To   
(DD/MM/YY) (DD/MM/YY)

14. During this period will the injured person be able to attend to his/her normal duties ?

Yes

No

a. If yes, form what date?

(DD/MM/YY)

b. If not, Please state probable date of his / her being able to attend to his normal duties

(DD/MM/YY)

15. Present Condition

16. Nature of disablement (to be filled ONLY in case of permanent disablement)

a. Permanent Total Disablement

Yes

No

b. Permanent Partial Disablement

Yes

No

If yes please specify percentage:

17. Any other remarks you wish to make

I hereby certify that the injuries sustained by the person mentioned above are in accordance with the nature of the accident as described to me and that I treated him for the said injuries

Doctor s Name Qualifications Registration No Address  Phone No.  E-mail	Signature of the Doctor Date
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**Additional Information :**