

National Insurance Co. Ltd.,

Mumbai Corporate Regional Office, National Insurance Building, 2nd Floor, 14, Jamshed Ji
Tata Road, Churchgate, Mumbai 400 020

Fax No : 022 22026496 email : 251100@nic.co.in

GROUP PERSONAL ACCIDENT – CLAIM INTIMATION CUM CLAIM FORM

Issuance of this form is not to be taken as an admission of liability

Policy		Claim No.:	
		Date of Claim registration:	
	Policy No. _____	Policy Period	__ / __ / ____ to __ / __ / ____

1. Name of the TAG owner			
2. ETAG No.			
3. Vehicle No.			
4. Name & Address of the Claimant #	Flat/ Door No		Building name
	Road		
	Area		
	City		Pin code
	State		
	Phone No.		
	Mobile No.		
	E-mail Id		
5. Details of the Accident			
a. Date of accident:			
b. Time of accident:			
c. Place of accident:			
d. Date of death:			
e. Claim Amount:			
f. Brief Description :			

6. Documents submitted (Tick the box)	
a) Attested copy of FIR Report * <input type="checkbox"/> b) Attested copy of Post Mortem Report <input type="checkbox"/> c) Death Certificate- Original <input type="checkbox"/> d) TAG owner Declaration for driver (Only Corporate) <input type="checkbox"/> e) PAN card copy of the Claimant or UID/Aadhar <input type="checkbox"/> f) Copy of Valid Driving License <input type="checkbox"/> g) Panchnama <input type="checkbox"/>	Additional Requirement: Viscera Report / chemical analysis report in case where post mortem report shows the cause of death due to poisoning or alcohol or any substance abuse. <input type="checkbox"/>

I/We hereby declare that the foregoing statements made by me/us are true in all respects, that I/We have not attempted to conceal from the Company anything with which it ought to be made acquainted and that if I/We have made or in any further declaration the Company may require shall make any false or fraudulent statement or untrue averment whatever, the Claim shall be void and my/our right to compensation forfeited. I am/ We are willing if required, to make and provide to the Company a statutory Declaration of the whole of the foregoing statement or of any other statement made in connection with this claim.

Name of Insured.#.....

should be of the same person

Signature of Insured #

Contact Details #