

GODIGIT GENERAL INSURANCE COMPANY LIMITED
GROUP TOTAL PROTECT

CLAIM FORM FOR DEATH / PERMANENT TOTAL DISABLEMENT

This form is issued without admission of liability and must be completed and returned within 18 0days from the date of accident. No claim can be admitted unless a medical overleaf be furnished at the expense of the claimant.

Master Policy No:

Insured Name	
Address of the Insured and State	
Age/Date of Birth	
Occupation– Fisher: Fish workers, fish farmers and any other categories of persons directly involved in fishing and fisheries allied activities, please tick Yes/No	Yes/No
When did the accident occur? State date and time	
Where did it occur?	
Give full particulars of the cause of accident and the injuries sustained.	
Give name and address of the witness of the accident	
Were you moved to hospital immediately after the accident?	Yes/ No / Not applicable
If Yes Give name and address of the Hospital	
Name of the Doctors who attended	
State where and when a Medical or other officer of the Company can visit you, if necessary	
State the number of days you have been necessarily and entirely confined to Bed, Room or House as the sole and direct result of the Injuries sustained.	
If still confined, state probable duration of confinement.	

Signature of the Insured / Nominee

TO BE COMPLETED BY HOSPITAL AUTHORITIES (or) appropriate certificate must be enclosed

As in-patient /out-patient/emergency case

Name and address of the Hospital	
Date of Admission	
Date of discharge	
Nature of Injury Particulars of the Treatment	
Has the accident resulted into loss of hand/s, foot/feet or eye/s or permanent total disability of any other type which may prevent insured from engaging in or being occupied with or giving attention to any employment or occupation whatsoever? If yes, please give details	
Hospital Expenses (Please attach original bills and death/discharge summary)	

Date: / /

Signature of the Competent Authority of Hospital/ Nursing Home

Name Designation Rubber Stamp of Hospital

To be completed by Nominee in the event of death of the Insured

Policy No:

Details of Nominee:

Full Name	
Address	
Age	
Relationship with the deceased	
Signature of the Nominee	

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

I HEREBY DECLARE that the truth of the above particulars is true in every respect, and I agree that if I have made, or if shall make false or untrue statement, suppression or concealment, my right to compensation shall be absolutely forfeited.

Date: / /

Signature (with Full Name)

DOCUMENTS TO BE SUBMITTED BY THE CLAIMANT

- CLAIM INTIMATION-Mandatory
- CLAIM FORM DULY FILLED AND SIGNED BY INSURED-Mandatory
- CERTIFIED COPY OF FIR, wherever applicable
- CERTIFIED COPY OF PANCHANAMA, wherever applicable
- CERTIFIED COPY OF POSTMORTEM REPORT, wherever applicable
- CERTIFIED COPY OF APPROPRIATE AUTHORITY-Mandatory
- ORIGINAL DEATH CERTIFICATE, wherever applicable
- FAMILY MEMBER CERTIFICATE, if applicable
- NEWS PAPER CLIPPINGS, wherever applicable
- MEDICAL REPORT/DEATH SUMMARY FROM HOSPITAL/INDEMNITY BOND, as applicable

KYC NORMS TO BE SUBMITTED FOR INSURED AND NOMINEE:

- NEFT BANK ACCOUNT FORM WITH CANCELLED CHEQUE – Mandatory.
- DISCHARGE VOUCHER SIGNED AFTER AFFIX Re.1/- REV.STAMP - Mandatory KYC NORMS TO BE SUBMITTED FOR INSURED AND NOMINEE.
- AADHAR CARD COPY -Mandatory
- PAN CARD COPY -Mandatory