CLAIM FORM FOR HOSPITALISATION / PERMANENT PARTIAL DISABLEMENT

POLICY NUMBER: _____

This form is issued without admission of liability and must be completed and returned within 180 days from the date of accident. No claim can be admitted unless a medical overleaf be furnished at the expense of the claimant.

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

TO BE COMPLETED BY HOSPITAL AUTHORITIES (or) appropriate injury Certificate /MLC / Discharge 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 toe/s, phalanx/phalanges/s, hearing of ear/s, forefinger/s, thumb/s, Metacarpal/s, carpal/s, or permanent partial 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 discharge summary)	

Date: / /

Signature of the Competent Authority of Hospital /
Nursing Home Rubber Stamp of Hospital Name Designation

Declaration to be signed by the insured

I Hereby declare that I have suffered / sustained the injuries above described and warrant the truth of the above particulars 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.

Dated: / / Signature