KERALA STATE INSURANCE DEPARTMENT

GROUP PERSONAL ACCIDENT SCHEME

CLAIM FORM

This Claim Form should be completed by the Insured Person or his/her eligible family member, as the case may be. Issue of this Claim Form does not tentamount to admission of liability by the Department

1. Full Name of the Insured Person

2. Official Designation of the Insured Person

3. Official Address of the Insured Person

PIN : Ph. :

4. Full Name of the Claimant

5. Residential Address of the Claimant

PIN : Ph. :

6. Date, Time and Place of Accident

Date : Time : AM/PM

Place :

7. Full Description of the Accident (Please attach separate sheet, if required)

8. Details of Injury and Treatment in case of no-fatal accident (Please attach separate sheet, if required)

9. Details of any other insurance policy covering the Insured Person against Personal Accident

Name of Policy

Name of Company

DECLARATION

I hereby declare that the foregoing statement are true in all respect and that I have not concealed from the Department which ought to have been disclosed and I agree that if I have made or shall in any further declaration that the Department may require, make any false or fraudulent statement or suppress, conceal or aver untruly, my right to compensation shall be forfeit.

Witness:

1.

2.

Place : Signature :

Date : Name of Claimant :