Personal Accident Insurance Claim Form F. No. AC – 39

Policy No. 67050042130100000072
Branch/Unit. Divisional Office 670500
No.9, Infantry Road,
Bangalore-560001
Claim No. (To be filled
by the Insurance Company)

The New India Assurance Company Limited

Regd. & Head Office : 87, Mahatma Gandhi Road, Fort, Mumbai - 400 001.

TO BE COMPLETED BY THE INSURED

1. * (a) Name of the insured - Hindustan Aeronautics Ltd.

(b) Name of the injured Person :

(c) Address in full :

(d) Scale / Grade :

2.* (a) Date of the accident :
(b) Time of accident :
(c) Where it happened ? :
(d) Name and address of witness, if any :

3.* How did the accident occur ? :

4.* Nature of injury received :

5.* (a) Nature of disablement :

(b) Extent of disablement :

(c) Confined to bed : [From_____To_____]

(d) Confined to house : [From_____To_____]

(e) Present state of incapacity : (Just state the date of demise in case of death.)

6.* Name and address of doctor in attendance :

7. (a) Where and when can a Medical Officer of the Insurance Company visit you, if necessary? :

(b) Name of nearest Railway Station to your Residence and distance therefrom :

8.. (a) Are you insured in any other Office or Offices granting compensation for accident :

(b) If so state name and address of Company or Companies and amount of insurance :

9. Copies of Documents enclosed (please indicate) : (i)

(ii)

(iii)

(iv)

(v)

(vi)

(vii)

(viii)

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

Name_____

Signature_____

Address_____

_____

Date: _____

Place: _____

Fields marked * are mandatory.

CERTIFICATION BY THE HR DEPARTMENT

It is certified that the employee is a member of the HAL Personal Accident Insurance Scheme and the particulars furnished by him at Sl. No. (1) are correct.

Signature:

Name:

Place: Designation:

Date: Seal:

Forwarded to:-

The New India Assurance Company Ltd.
Divisional Office 670500
No.9, Infantry Road, Bangalore 560 001.
Fax No: 080-22866343

E-mail: mary.abraham@newindia.co.in
srilekha.gopal@newindia.co.in