HULL DEDUCTIBLE INSURANCE POLICY (AVIATION PERSONAL ACCIDENT POLICY)

(For Pilots, Navigators, Aircraft Flight Engineers, Aircraft Flight Technicians & other Crew Members)

CLAIM FORM

Claim No_____ Policy No._____

All questions must be answered fully. If there is insufficient space, kindly use a separate sheet which can be attached to this form. If any section is not fully completed or left blank, the form will be returned for completion.

The issue or acceptance of this form is not to be construed as an admission of liability by USGI.

A. The Insured

Name:_____

Address: _____
_____

Tel No.Office : _____ Mobile_____ Email_____

B. Policy Details

Policy No._____

Period of Insurance: _____to_____

C. Claimant
(a) Name:_____

Address: _____
_____

Tel No.Office : _____ Mobile_____ Email_____

Relationship with insured person _____

(b) Insured person's details

Name: _____

Sex: Male □ Female □

Date of Birth: _____/_____/_____

Occupation: _____

Employee/Member identification number (for group policies)
_____

Address where a Medical Practitioner on behalf of USGI can visit
_____
_____

D. Accident Details

Date of accident: (dd/mm/yy) _____/_____/_____

Time of accident: _____am/pm

Did it occur at work: Yes □ No □

Where did the accident occur

_____

How did the accident happen

_____

_____

Was the accident reported to Police Yes □ No □
If not, kindly state the reasons

_____

_____

Are there any witnesses to the accident Yes □ No □
If yes, kindly provide name(s) and contact details

_____

_____

Describe the nature of injuries received

_____

_____

Period of disability:

Total disability- confined to Bed: (dd/mm/yy) _____/_____/_____ to _____/_____/_____

Partial disability – confined to House (dd/mm/yy) _____/_____/_____ to _____/_____/_____

If partially disabled, kindly state the daily duties of usual occupation which cannot be performed

_____

In case of death of insured person, kindly provide following information:

Date and time of death _____hrs on ____/_____/_____

Whether post-mortem was conducted Yes □ No □

If not, please give reason_____

E. Hospitalisation/treatment Details

Name & contact details of doctor first consulted after the accident

_____

_____

Name and contact details of other doctors consulted

_____

_____

Name and contact details of claimant's usual medical practioner

_____

_____

Whether hospitalized following the accident Yes □ No □
If Yes, name & address of hospital _____

Period of hospitalization: (dd/mm/yy)_____/_____/_____ to_____/_____/_____

F. Other Insurances

Details of any other insurance (arranged by self, spouse, parents or employer) under which claimant/deceased is covered

Name of insurer	Policy Number	Period of insurance	Coverage	Sum insured

G. Declaration

1. I/We agree to provide additional information to the Company if required. I/We are the above insured, and I/We guarantee the truthfulness of the above statement in every respect, to the best of my/our knowledge and belief, and if I/We have made any false or fraudulent statement, or have suppressed or concealed any material facts, the policy will be cancelled and all rights in respect of past or future claims will be reserved.

2. I/We understand that the Company reserves the right to verify & obtain my identity, address, facts and documents relating to the policy and claim with rating agencies, third parties or service providers.

3. I/We have read and understood the privacy policy of the Company at www.universalsompo.com and I/We unconditionally agree and bind myself/ourselves to all the terms and conditions of your privacy policy as amended from time to time.

4. I/We have received a list of documents with this claim form and have understood all the requirements to be fulfilled for scrutiny and processing of this claim and the Company shall not be responsible for any delay in scrutiny and processing/settlement of claim due to claimant's non-fulfilment of requirements including non-submission of the required documents/information as mentioned above.

5. I/We declare that the details of all persons having an interest in the property in respect of which the claim is being made are provided as per the proposal form or by way of an endorsement in the policy. Except as disclosed in this claim form, no claim for the same or similar loss has been made or lodged with any other insurance company.

6. I/We hereby give my/our consent to the Company to verify and obtain my/our identity/address proof/ bank details as well as the identity/address proof of the Insured/ Beneficial Owner through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC.

7. I authorize any hospital, physician or any other medical provider who has attended or examined me/insured person to furnish USGI such details of medical history/treatment as they may require.

Signature of Insured/claimant: _____

Date: _____

To be completed by Employer (for Group Policies)

This is to certify that:

Mr./Ms_____, working as _____, permanent Employee Id No._____ covered under Group Personal Accident Policy No._____ was on leave for the period _____/_____/_____ to _____/_____/_____. Mr/Ms. is covered under the Policy for a Capital Sum insured of Rs._____. The total number of employees on permanent rolls as on the date of accident was_____. The above information is true to the best of my knowledge and we agree to provide any further information that may be required.

Signature of Authorised signatory: _____

Date: _____

Name & Designation of Authorized signatory: _____

Company Seal: _____

Documents to be attached to the claim form:

- Police Report/Panchnama
- Post Mortem Report
- Death Certificate
- Copies of record of treatment including X rays, investigation reports
- Cash memos, Bills and receipts in case medical expenses are covered
- Any other document as may be required

Medical Attendant's Certificate

Name of patient: _____

Occupation: _____

How long have you known this patient_____

Are you his/her usual Medical Attendant Yes □ No □

Kindly state the nature of and extent of injuries

_____

_____

Is the injury consistent with claimant's description of the accident Yes □ No □

Are the injuries connected with any previous accident, infirmity or disease Yes □ No □
If yes, please provide details

_____

_____

Will the recovery be retarded due to above Yes □ No □
If yes, kindly provide details

_____

When were you first consulted for this injury/disability (dd/mm/yy)_____/_____/_____

Please give details of other consultations – Dr's name, address

_____

_____

Are you still treating the patient for the injury/disability Yes □ No □

Kindly provide details of treatment prescribed

_____

_____

If X-ray has been done, kindly state the findings and Radiologist's report

_____

_____

If hospitalized, name of hospital

_____

Period of hospitalization (dd/mm/yy)_____/_____/_____ to_____/_____/_____

Date & Nature of surgical procedure, if any (dd/mm/yy)_____/_____/_____.

_____

Are there any complications which may retard the recovery

_____

Has the patient suffered from similar injury/disability previously? Yes □ No □
If yes, when, nature and duration of the

_____

_____

Was the patient under the influence of intoxicants or drugs at the time of accident Yes □ No □

While under your care and direction, how long was or will the patient be:

a) Totally unable to perform each and every duty of his/her usual occupation

From (dd/mm/yy)_____/_____/_____ to_____/_____/_____

b) Partially disabled from performing his/her usual occupation

(dd/mm/yy)_____/_____/_____ to_____/_____/_____

Nature of disablement (in case of permanent disability)

Permanent Total disability

_____

Permanent partial disability, If yes, give details and percentage of disability

_____

In case of death of insured person, kindly state the cause of death _____

Prognosis

Please comment on any additional factor that may prolong recovery from injury/disability

_____

_____

I certify that I have personally attended to the named above patient and the above statements are correct.

Signature*:

Name:

Qualification:

Reg.No.:

Address:

Date:

*Kindly Affix official seal/stamp