UNITED INDIA INSURANCE COMPANY LIMITED

REGD & HEAD OFFICE: NO 24 WHITES ROAD CHENNAI – 600 014

PROFESSIONAL INDEMNITY CLAIM FORM (DOCTORS)

CLAIM No ._____

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

The completion and return of this form to the Company should not be delayed if any of the particulars required cannot be immediately given, They may be forwarded to the Company afterwards as soon as possible (If space found insufficient please attach separate sheet).

1. (a) Name of Insured

   β) Address

   χ) Qualification Registration No.

   δ) Policy Number

   ε) Period of Policy

   ϕ) Limits of Indemnity under the policy.

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2. Particulars of Incident :

   (a) Date of Occurrence :

   (b) Place of Occurrence :

   χ) Who is directly responsible for the injury/ loss?

   δ) Give details of treatment :

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3. (a) Who has made the claim on you ?
   (If claim has been made in writing, attach a copy of the demand/legal notice received and of the bill,

if any, submitted).

β) Name and Address of the Patient.

χ) His age and occupation.

δ) When did he first consult.

ε) His general physical condition now.

φ) Give full particulars of any other relevant aspect

4. Amount claimed as damage from you :

5. (a) Give the names and addresses of Person who witnessed the incident :

β) has the incident been reported to IMC or any other authority ? If so, state to whom and attach A copy of the report submitted. :

χ) What action, if any, has been taken by the authority ?

Give particulars of other insurance if any, in respect of the same risk. :

6. Has any claim been made upon you before.

I/We the above named, do hereby, to the best of my/our knowledge a belief, warrant the truth of the foregoing statements in every respect; and I/We agree that if I/We have made, or in any further declaration the Company may require in respect of the said accident shall make any false or fraudulent statement, or any suppression or concealment my/our claim shall be absolutely forfeited, and the Policy shall be null and void.

Witness : Signature_____ Insured' s Signature _____

Name _____ Date _____

Address _____

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Date _____