

Issuing office : \_\_\_\_\_

Date of Issue : \_\_\_\_\_

Claim No : \_\_\_\_\_

## PERSONAL ACCIDENT DEATH CLAIM FORM

**Royal Sundaram General Insurance Co. Limited**

(Formerly known as Royal Sundaram Alliance Insurance Company Limited)

Corp. Office : Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR) Karapakkam, Chennai - 600097.

Regd. Office : 21, Patullos Road, Chennai - 600 002.

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

Please ensure that all questions are answered in Capital Letters using an ink pen

Policy Number	<input type="text"/>	Certificate Number	<input type="text"/>
Card Number / Account Number	<input type="text"/>	Name of the Bank	<input type="text"/>

#### 1. Insured/Insured Person

Name of the Insured/Insured Person	<input type="text"/>						
Name of the injured Person	<input type="text"/>						
Address for Correspondence	<input type="text"/>						
Telephone Daytime / Mobile Number	<input type="text"/> <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Telephone Evening	<input type="text"/> <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
E-mail ID	<input type="text"/>						

#### 2. Details of the accident

Date of the accident	<input type="text"/> (DD/MM/YY)
Time of accident	<input type="text"/> (AM/PM)
Place of accident	<input type="text"/>
Nature and cause of accident	<input type="text"/>
Was the accident reported to the Police?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes please give the address of the Police Station	<input type="text"/>
If No please give reason why	<input type="text"/>
First Information Report Number & Date	<input type="text"/>

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### 3. Hospital Details

Name of the hospital where the person was admitted immediately after the accident

Address of the hospital

Name of the hospital where the postmortem was conducted

Address of the hospital

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### 4. Other Insurance Details

Does the injured person have any other Personal Accident insurance?

Yes ☐

No ☐

If yes , please give the name and address of the Insurance company

Policy Number

Amount Insured for

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### 5. DECLARATION

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

#### Witness

Signature/thumb impression

Name

Date

  
(DD/MM/YY)

Full Address

#### Legal Heir / Nominee

Signature / thumb impression of First legal heir

Name

Date

  
(DD/MM/YY)

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### CERTIFICATE FROM THE EYE WITNESS TO THE ACCIDENT

I hereby certify that I was present when the accident occurred to Miss/Mrs/Mr. \_\_\_\_\_ on \_\_\_\_\_ (DD/MM/YY) in the manner stated overleaf. It was caused by \_\_\_\_\_

which was\*/was not\* his/her wilful act and he/she was\*/was not\* under the influence of intoxicating liquor / drugs at The time of accident.

\*Strike out which is not applicable

Date

(DD/MM/YY)

Signature /  
thumb impression  
of the eye witness

Name

Place

Address

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**PLEASE CHECK THAT ALL QUESTIONS HAVE BEEN ANSWERED IN FULL & THE FORM SIGNED AND DATED. KINDLY SEND THE FOLLOWING DOCUMENTS**

Death certificate in original

First Information Report - Photocopy duly attested by the issuing authority

Postmortem report

Panchanama / Accident report

Chemical analysis report of viscera / blood sample

Admission / Discharge / Death summary issued by hospital authority

English translation of vernacular documents

Certificate from the Airline that the deceased was travelling as a passenger (in case of air accident.)

Original Legal Heir Certificate (in case nomination has not been filed by the deceased)

**Additional Information :**



**ROYAL SUNDARAM INSURANCE**  
Sundaram Finance Group

**Royal Sundaram General Insurance Co. Limited**

Formerly known as Royal Sundaram Alliance Insurance Company Limited)

Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097. Registered Office: 21, Patullos Road, Chennai - 600 002.

Royal Sundaram IRDAI Registration No.102 | CIN:U67200TN2000PLC045611

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