Universal Sompo
General Insurance Co. Ltd.

PRADHAN MANTRI SURAKSHA BIMA YOJANA

CLAIM FORM

This form is issued without admission of liability and must be completed and returned within 7 days after its receipt.

Claim No._____	Policy No._____
1. Name in Full_____ Address_____ _____ Contact Number_____	2. Name of the Bank with address_____ _____ _____ Saving Account No._____
3. A) When did the accident / death occur? State Day, Date and Hour B) Where did it occur? C) Give full particulars of the cause of death / injuries sustained.	
4. Give name and address of the attending Doctors	
5. State where and when a Medical or other Officer of the Company can visit you, if necessary.	
6. A) In case of Death, Original FIR / Post Mortem Report/ Death Certificate to be attached. B) In case of Disability, Disability Certificate from Civil Surgeon to be attached.	

I HEREBY DECLARE and warrant the truth of the foregoing particulars in every respect, and I agree that if I have made, or if shall make false or untrue statement, suppression or concealment, my right to compensation shall be absolutely forfeited.

Dated _____ Signature_____

(Claimant)