# Accident or Permanent Disability/ATM Cash Withdrawal or Over the Counter & Loss of Personal Documents Claim Form

CNIC No. of the Policy Holder _____ Claim No._____

Account no. of the Policy Holder _____

This form is issued without admission of liability, and must be completed and returned within **seven days after its receipt**. No claim can be admitted unless a medical certificate overleaf be furnished at the expense of the Claimant.

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| 1. | Policy Holder's Name in full: _____<br><br>Residence: _____<br><br>Business Address: _____<br><br>(Present Business or occupation)<br>If more than one state all) | Present Age: _____ Years<br><br>Height: _____ft. _____ in.<br><br>Weight: _____st. _____lbs. |
| 2. | a) When did the accident/theft occur? State day, date and hour.<br><br>b) Where did it occur?<br><br>c) Give the names and addresses of any witnesses of the accident/theft<br><br>d) Have you previously claimed or received compensation under an accident and/or Theft Policy? If so, please give particulars.<br><br>e) Is/Was the customer insured elsewhere?<br><br>f) If so, give the name of each Company or Insurer, and the amount entitled to claim.<br><br>g) Has the FIR been registered with the claim?<br><br>h) Nature of the Loss and circumstances of the loss | |
| **PLEASE FILL THE FOLLOWING SECTION INCASE OF ACCIDENT/PERMANENT DISABILITY ONLY** | | |
| 4. | a) Name and address of the doctor who attendedb) Name and address of Ordinary Medical Attendant<br><br>b) Name and address of the branch staff who had been reported about the incident along with the reporting date and time<br><br>c) State where and when a Medical or other officer of the Company can visit the insured customer,<br><br>d) State the number of days the insured customer had been necessarily and entirely confined to Bed, Room or House, as the Sole and direct result of the injuries sustained _____<br><br>e) If still confined to any, state which.<br><br>f) Has the insured customer in any way attended to business or work during the above period?<br><br>g) In case of permanent disability, give full particulars of the cause and the injuries sustained<br><br>h) In case of accidental death, give full particulars of the cause and the date and time of death | To Bed<br>For_____days<br>From _____<br>to _____<br>both inclusive<br><br>To Room<br>For_____days<br>From _____<br>to _____<br>both inclusive<br><br>To House<br>For_____days<br>From _____<br>to _____<br>both inclusive |

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

I claim to be paid the sum of _____ or the total sum _____ which I agree to accept in full settlement of my claim on the Company.

_____ _____

DATE POLICY HOLDER/CLAIMANT'S SIGNATURE