CIN No. U66010RJ2006PLC029979
IRDA Registration Number: 137

Shriram General insurance Co. Ltd.
IN PARTNERSHIP WITH THE **Sanlam** GROUP
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Optional Travel Insurance For E-Ticket Passengers of IRCTC - Claims Form

The issue of this form is not to be taken as an admission of liability. Please ensure that all columns of the claim forms are filled in by the insured and no column remains unanswered. No claim will be admitted without a Medical Report as per format to be obtained at claimant's expense. Attach Separate Sheet if the space is not sufficient.

SGI Certificate Number:	PNR Number:	Claim number:

Period of Insurance:	
Insured:	
Address:	
Contact Number:	Landline:- Mobile:-
E-mail:	
Sum insured	

1. PERSONAL DETAIL

1.	Name of claimant	
2.	Address	
3.	Occupation	
4.	Age	

2. DETAILS OF ACCIDENT:

1.	Time and Date	
2.	Place and Location	
3.	Cause (Description)	

3. DETAILS OF INJURIES:

1.	Specify Injured Part(s) of Body	
2.	Total Disablement if any	
3.	Percentage (In Words)	**(%)**

4. WITNESSES:

Name	**Address**	Phone No

5. POLICE REPORT:

Has a complaint been lodged with the Police station?
If Yes, by whom, when & at which Police station? (Attach a copy of the police report).

6. TREATMENT DETAILS:

	Name	**Address**	**Phone No**	Registration No
(a)Doctor				
(b) Hospital(s)				

7. OTHERS:

1.	Total Confinement (This should be the actual days when fully confined to bed on Medical Advice)	**From** **To**
2.	Have you made any claims in the PAST? If YES, please give details including accident and Insurance details	**Yes/No**
3.	Are you insured under any other policy? If YES, please give full details	**Yes/No**

I, undersigned confirm that the above given details are true & correct to the best of my knowledge.

I further authorize the hospital, doctor, laboratory, organization, establishment or any other body or person dealt with in the course of this claim to give any information or document sought for by the Insurance Company.

Date:

Place: Signature of the Insured/Claimant

ATTENDING PHYSICIAN'S STATEMENT

1.	Name of Injured Person	
2.	Age	
3.	Address	
4.	Nature of the Accident and Details of Injuries Sustained	
5.	Does the Cause of Accident as stated by the Claimant tally with the Injuries noticed by you?	
6.	Are the injuries solely due to the accident or traceable to any previous injuries/ disease/ infirmities?	
7.	Was the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition?	
8.	Was the Claimant hospitalized? If so for what period?	
9.	Was he under the influence of intoxicants or drugs at the time of accident	
10.	Are you his usual medical Attendant? If you have treated him for any previous illness or injury, please give details	
11.	Have other Doctors been in Attendance or Consultation? If yes, Please give details	
12.	Has this accident been reported to the Police Authorities? If yes, Case No: Police Station :	
13.	Details about disablement due to accident	

Doctor's Signature:	**Reg. No:**
Doctors Name:	**Date :**
Address and Phone No:	