

Claim No. _____

INDUSIND INLAND TRAVEL CARE POLICY - CLAIM FORM B

*Policy No. / Certificate No. _____		
PERSONAL ACCIDENT/ACCIDENTAL DEATH & DISMEMBERMENT-COMMON CARRIER		
1. Details of Accident		
Flight No.	PNR No.	
When Did The Accident Happen?	_____ a.m./p.m.	
Date of Death	DD / MM / YYYY	Time of Death _____ a.m./p.m.
Location _____		
Please provide the necessary details about the accident _____		
Please state the nature and extent of loss _____		
Please state the amount claimed _____		
2. DETAILS OF WITNESS		
WITNESS 1		
Name	☐ Mr. ☐ Mrs. ☐ Ms. ☐ M/S. F I R S T M I D D L E L A S T	
Address for Communication Flat/Building/Door/Block No. _____		
Road/Street/Sector	Area _____	
Taluka/Village/District/City	Pin Code _____	
State	Country _____	
Phone _____	Mobile _____	
Email ID _____	Fax _____	
WITNESS 2		
Name	☐ Mr. ☐ Mrs. ☐ Ms. ☐ M/S. F I R S T M I D D L E L A S T	
Address for Communication Flat/Building/Door/Block No. _____		
Road/Street/Sector	Area _____	
Taluka/Village/District/City	Pin Code _____	
State	Country _____	

Phone			Mobile
Email ID			Fax

3. **Treatment Details**

Please specify whether the insured person was hospitalised for the treatment of injury due to the accident? ☐ Yes ☐ No

If yes, period of hospitalisation From DD/MM/YYYY To DD/MM/YYYY

Please provide name of the hospital/nursing home where the insured person was treated for the injury sustained due to the accident?

Address for Communication Flat/Building/Door/Block No.			
Road/Street/Sector		Area	
Taluka/Village/District/City		Pin Code	
State		Country	
Phone		Mobile	
Email ID		Fax	

Please provide the name of physician/surgeon who attended the insured person during the treatment for the injury sustained due to the accident?

Address for Communication Flat/Building/Door/Block No.			
Road/Street/Sector		Area	
Taluka/Village/District/City		Pin Code	
State		Country	
Phone		Mobile	
Email ID		Fax	

Have the police authorities been informed of this accident?

Have the following documents, been submitted?

a. Copy of FIR	☐ Yes ☐ No	b. Death Certificate	☐ Yes ☐ No
c. Police Report	☐ Yes ☐ No	d. Post Mortem Report (in case of accident death)	☐ Yes ☐ No

4. Attending Doctor/Physician's Statement (To be filled up the by Attending Doctor/Physician)

 Name of Insured Person ☐ Mr. ☐ Mrs. ☐ Ms. FIRST MIDDLE LAST

Age _____ Yrs.

 Address Flat/Building/Door/
Block No.

Road/Street/Sector

Area

Taluka/Village/District/City

Pin Code

State

Country

Phone

Mobile

Email ID

Fax

Please state nature of the accident and details of injuries sustained

Does the cause of accident as stated by the insured person tally with the injuries noticed by you?

Are the injuries solely due to the accident or traceable to any previous injuries/disease/infirmities?

Was the insured person suffering from any disease/injury which may have contributed to the accident or likely to aggravate his/her condition.

Was the Insured person hospitalized? If so for what period? From DD/MM/YYYY To DD/MM/YYYY

Please provide the details of treatment given and operations performed, if any?

Was he/she under the influence of intoxicants or drugs at the time of accident?

Has this accident been reported to the police authorities? If yes

Case No. _____ Police Station _____

 Name of Attending Doctor/
Physician Dr. _____

 Address Flat/Building/Door/
Block No.

Road/Street/Sector

Area

Taluka/Village/District/City

Pin Code

State

Country

Phone		Mobile	
Email ID		Fax	
_____ Attending Doctor / Physician's Signature		Date: DD/MM/YYYY Regn. No. _____	

PROPOSER'S BANK DETAILS

Name of the Bank Account Holder	☐ Mr. ☐ Ms. ☐ Mrs. F I R S T M I D D L E L A S T		
Bank Account No.:		Account:	☐ Saving ☐ Current
Name of the Bank			
Branch			
MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)			
IFSC Code (11 character code appearing on your cheque leaf)			
☐ I understand that any refund due on the premium payment / any payment / claims to be directly credited to my aforesaid Bank Account.*			
*As per IRDAI, its mandatory that all payments made to the insured are only through electronic mode.			

* Mandatory details to be filled

PEP DECLARATION:

Are you a Politically Exposed Person (PEP)?	☐ Yes ☐ No
If yes, please mention the position held	
Is any of your close relation or family member a PEP?	☐ Yes ☐ No
If yes, please mention the name and relation and the position held by such close relative/family member.	

I hereby declare that in future if me, any of my close relatives or any of my family member attains a position of PEP then I shall confirm the same to IndusInd General Insurance Co. Ltd as a mandate. I understand that this is a crucial information under the PMLA Rules and AML/CFT Guidelines and shall confirm that the answers given by me is true. In case the company comes to know that this is a misrepresentation and concealment of information then the policy shall be put on hold for scrutiny by the company and I shall be solely responsible for the same.

Note :

"Politically Exposed Persons" (PEPs) shall have the meaning assigned to it under sub clause (db) of clause (1) of Rule 2 of the Prevention of Money Laundering (Maintenance of Records) Rules, 2005."

(db) "Politically Exposed Persons" (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials".

AML Guidelines

1. I/We hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been /will be paid out of proceeds of crime related to any of the offense listed in Prevention of Money Laundering Act,2002.
2. I Understand that the Company has the right to call for document to established sources of funds.
3. The Insurance Company has right to cancel the insurance contract in case I am/have been found guilty by competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India.

Place: _____

Date: _____

Signature of Proposer

GENERAL DECLARATION:

I understand that as per the new AML/CFT Guidelines issued IndusInd General Insurance Co. Ltd will be verifying my details pertaining to KYC and PAN provided at the time of proposal.

I further, do hereby agree and consent that in the case of the event of a mismatch of information provided by me in the proposal form, identification proof, and address proof at the time of issuance of the policy. I request IndusInd General Insurance Company Limited to issue the policy with the details appearing as per my proposal form. I will be solely responsible for any consequences arising out of the difference in detail given by me during the verification of supporting documents provided by me at the time of issuance of the policy or otherwise.

HEALTH CARE ADDRESS:

Health Care Unit: IndusInd General Insurance, No.1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad - 500081. **Email:** healthcare@indusindinsurance.com.