The New India Assurance Company Limited

Regd & Head Office: New India Assurance Building, 87, M.G. Road, Fort, Mumbai - 400 001.

Policy Issuing Office : Bandra Divisional Office 142300

C-6,NCL Business Premises, 1st Floor, Bandra-Kurla Complex, Mumbai 400051.

RuPay CARDHOLDER'S PERSONAL ACCIDENT INSURANCE CLAIM FORM 2025-26

POLICY NUMBER: 14230042240100000687

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

RuPay CARD TYPE [PLATINUM / SELECT CARDS]	
NAME OF RUPAY CARDHOLDER	
AADHAR NUMBER OF CARDHOLDER	
BANK ACCOUNT NUMBER	
ACCOUNT OPENING DATE	
RUPAY CARD NUMBER	

NAME OF NOMINEE [CLAIMANT]	
MOBILE NUMBER	
EMAIL ID	
ADDRESS OF CLAIMANT	

DATE AND TIME OF ACCIDENT	
PLACE OF ACCIDENT	
BRIEF DESCRIPTION OF ACCIDENT [MANDATORY IN ENGLISH / HINDI] IF SPACE IS INSUFFICIENT,PLEASE ATTACH SEPARATE SHEET.	

NATURE OF CLAIM	DEATH / DISABLEMENT
ANY OTHER RuPay CARD HELD BY THE SAME PERSON IF YES PLEASE GIVE DETAILS	YES / NO

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

BANK SEAL AND SIGNATURE		SIGNATURE OF CLAIMANT	

WITNESS CERTIFICATE

[TO BE FILLED UP AND SIGNED BY AN EYE WITNESS TO THE ACCIDENT IF ANY]

I hereby certify that I was present when the Accident occurred to Mr./ Ms._____on the _____day of _____20 ___in the manner stated by him/her over leaf, that it was caused by _____which * was / was not his/her wilful act and that he /she * was / was not under the influence of intoxicating liquor at the time.

*Strike out which is not applicable

SIGNATURE & DATE

NAME OF WITNESS
ADDRESS
OCCUPATION

MEDICAL CERTIFICATE for DISABILITY CLAIMS ONLY

Disability Claims must be supported by medical evidence furnished by the Insured and at his expense.

NAME OF INJURED PERSON [CLAIMANT]	
SEX : [MALE / FEMALE]	AGE :
NATURE OF ACCIDENT	
WHETHER THE INJURIES ARE CONSISTENT TO THE DESCRIPTION OF ACCIDENT.	
DATE ON WHICH YOU FIRST ATTENDED THE CLAIMANT FOR THE INJURY	
HAS THE CLAIMANT BEEN DISABLED TOTALLY OR PARTIALLY	
IS THE CLAIMANT SUFFERING FROM ANY DISEASE/ ILLNESS/SYMPTOMS APART FROM THE INJURY WHICH MAY TEND TO RETARD RECOVERY? IF YES, PLEASE GIVE DETAILS.	
TYPE OF DISABILITY	

Having personally examined the above named Insured, I certify that the above statements are correct and that the insured person is necessarily disabled by the accident referred to

Signature : _____

Name & Qualification : _____
Address : _____
Date : _____