

EMI SHIELD

CLAIM FORM

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

Policy Number: _____

Claim Number: _____

A. POLICY HOLDER DETAILS

Name of the Insured: _____		
Date of Birth: _____	Age: _____	☐ Male ☐ Female
Address: _____		
City: _____	State: _____	Pin Code: _____
Mobile Number : _____	Email ID: _____	

B. CLAIMANT DETAILS (IF DIFFERENT FROM POLICY HOLDER)

Name of the Claimant: _____		
Relationship with Insured: _____		
Date of Birth: _____	Age: _____	☐ Male ☐ Female
Address: _____		
City: _____	State: _____	Pin Code: _____
Mobile Number : _____	Email ID: _____	

C. DETAILS OF ACCIDENT/INCIDENT

Date of Accident/Incidence: _____		Time of Accident: _____ A.M./P.M.	
Cause of Accident/Incidence: _____			
Details of Accident/Incidence: _____			
Nature of Injury: _____			
Was the accident reported? (if yes, please attach FIR/MLC/Police report) ☐ Yes ☐ No			
Name & address of hospital: _____			

Date of admission: _____		Date of discharge: _____	
Nature of hospitalization: ☐ Medical ☐ Surgical			
Treatment received: _____			

D. CLAIM DETAILS

Type of claim: _____

Total claimed amount: _____

Bank account details:

Name of the account holder: _____

Bank name: _____

Branch address: _____

Account number: _____

IFSC code: _____

E. For which benefit do you claim? [Please tick () the appropriate box]

Benefit	Amount Claimed
☐ EMI Protection	
☐ Accidental Permanent Total Disability	
☐ Death	

F. DECLARATION

I/We confirm that the information provided above is accurate and complete to the best of my/our knowledge. I/We acknowledge that any false or misleading information may result in the rejection of this claim.

Name of Insured/Claimant: _____

Place: _____

Signature: _____

Date: _____