

THE NEW INDIA ASSURANCE COMPANY LIMITED

CLAIM No.

Regd & Head Office: New India Assurance Building, 87, Mahatma Gandhi Road, Bombay - 400 001.

MALPRACTICE LIAB. / DOCTOR'S INDEMNITY CLAIM FORM

THE I	SSUE C	OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY		
particu	ılars red	on and return of this form to the Company should not be delayed if any of the quired cannot be immediately given, They may be forwarded to the Company soon as possible (If space found insufficient please attach separate sheet).		
1.	(a)	Name of Insured		
	(b)	Address		
	(c)	Qualification Registration No.		
	(d)	Policy Number		
	(e)	Period of Policy		
	(f)	Limits of Indemnity under the policy.		
2.	Particulars of Incident :			
	(a)	Date of Occurance :		
	(b)	Place of Occurrance :		
	(c)	Who is directly responsible for the injury/ loss?		
	(d)	Give details of treatment :		

5.	(b) (c)	has the incident been reported to IMC or any other authority? If so, state to whom and attach A copy of the report submitted. What action, if any, has been taken by the authority?				
5.	(b)	has the incident been reported to IMC or any other authority? If so, state to whom and attach	:			
5.		Person who witnessed the incident	:			
	(a)	Give the names and addresses of				
4.	Amo	Amount claimed as damage from you :				
_	(f)	Give full particulars of any other relevant aspect				
	(e)	His general physical condition now.				
	(d)	When did he first consult.				
	(c)	His age and occupation.				
	(b)	Name and Address of the Patient.				
		(If claim has been made in writing, attach a copy of the demand/legal notice received and of the bill, if any, submitted).				
3.	(a)	Who has made the claim on you?				

6. Give particulars of other insurance if any, in respect of the same risk.

7.	Has any claim been made upon you before.					
	warrant the truth of the that if I/We have made, respect of the said accidance.	do hereby, to the best of my/our knowledge a belief, foregoing statements in every respect; and I/We agree or in any further declaration the Company may require in ent shall make any false or fraudulent statement, or any ent my/our claim shall be absolutely forfeited, and the id.				
	Witness: Signature	Insured's Signature				
	Name	Date				
	Address					
		ECS Details of the Insured				
1	Name of the Insured (as appe	ring in the				
2	Bank Account)					
2	Bank Name					
3	Branch and address					
4	Bank Account No.					
5	Bank Account Type					

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IFSC Code MICR Code