

## FARMER'S PACKAGE POLICY (RETAIL)

## Claim Form - Personal Accident Insurance

Magma General Insurance Limited (erstwhile Magma HDI General Insurance Company Limited) | <u>www.magmainsurance.com</u> | E-mail: <u>customercare@magmainsurance.com</u> | Toll Free: 1800 266 3202 | Registered Office: Development House, 24 Park Street, Kolkata – 700016, West Bengal. | CIN: U66000WB2009PLC136327 | IRDAI Reg. No. 149 | Farmer's Package Policy (Retail) | Product UIN: IRDAN149RP0011V02201314 | For complete list of details on exclusions, risk factors, terms & conditions, please read the policy documents carefully before concluding a sale. | Trade Logo displayed above belongs to Magma Ventures Private Limited and is used by Magma General Insurance Limited under license. | Chat with MIRA on our website or say "Hi" on WhatsApp No. 7208976789 (CF.FPPR.ver10.12.24)



## FARMER'S PACKAGE POLICY (RETAIL)

## **CLAIM FORM - PERSONAL ACCIDENT INSURANCE**

Policy		Claim No.				
No		Date of reg	istration			
Deview						
Regiona	al/Branch Office Code					
Broker/Agent					Code	
5. a)Name of the insured person died/					· · · ·	
injured in the accident			Self/Spouse/Children			
<ul><li>b) Relationship with the employee/ member</li><li>c) Employee/member identification no.</li></ul>						
,	ate of the Accident					
<ul><li>b) Time of the Accident</li><li>c) Where it happened?</li></ul>						
d) Name & Address of the Witness						
7. How did the Accident occur?						
7. HOW	ala the Accident occur?					
8. Nature of Injury received (if to limb or						
Eye state whether right or left)						
9. a) Nature of disablement						
<ul><li>b) Extent of disablement</li><li>c) Period of temporary total disablement</li></ul>			(Fromto)			
	resent state of incapacity	ment	(FIOII	1	J)	
,						
10. Name and address of Surgeon in attendance						
11. Where and when can a Medical Officer of our						
Company visit you, if necessary? 12. a) Are you insured in any other Office or						
Offices granting compensation for accident?						
b) If so state name and address of company						
	or Companies and amount of Ir					

I/We hereby declare that the foregoing statements are true in all respects and that I/We have not attempted to conceal from the company anything with which it ought to be made acquainted and



also that if I/We 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/our right to compensation forfeited and am/are 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/We may make in connection with this claim.

Witness: Name.....

Signature .....

Signature of the Insured.....

Date .....