

The Oriental Insurance Company Limited

Head Office: A 25/27, Asaf Ali Road, New Delhi -110002

CLAIM FORM FOR PROFESSIONAL INDEMNITY ERRORS & OMISSIONS INSURANCE FORCHARTERED ACCOUNTANTS /FINANCIAL ACCOUNTANTS / MANAGEMENT CONSULTANTS / LAWYERS / ADVOCATES / SOLICITORS / COUNSELS

The completion and return of this form to the Company should not be particulars required cannot be immediately given, They may be forwards as soon as possible (If space found insufficient please attachment). (a) Name of Insured (b) Address	SION OF LIABILITY
	rded to the Company
(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 Occurrence :	
(b) Place of Occurrence:	
(c) Who is directly responsible for the injury/ loss?	
(d) Give details of treatment :	
3. (a) Who has made the claim on you? (If claim has been made in writing, attach a copy of the demand/legal notice received and of the bill, if any, submitted).	2D 4 N556P0090V0120050

CLAIM No.

	(b)	Name and Address of the Patient.
	(c)	His age and occupation.
	(d)	When did he first consult.
	(e)	His general physical condition now.
	(f)	Give full particulars of any other relevant aspect
4.	Amou	ant claimed as damage from you :
5.	(a)	Give the names and addresses of Person who witnessed the incident :
	(b)	has the incident been reported to IMC or any other authority? If so, state to whom and attach A copy of the report submitted.
	(c)	What action, if any, has been taken by the authority?
6.		particulars of other insurance, in respect of the same risk. :
7.	Has a	ny claim been made upon you before.
	warra if I/W respe suppr	the above named, do hereby, to the best of my/our knowledge a belief nt the truth of the foregoing statements in every respect; and I/We agree that le have made, or in any further declaration the Company may require in ct of the said accident shall make any false or fraudulent statement, or any ession or concealment my/our claim shall be absolutely forfeited, and the shall be null and void.
	Witne	ss: Signature Insured's Signature
		Name Date
		Address
		Date