PRADHAN MANTRI SURAKSHA BIMA YOJANA

CLAIM FORM

This form is issued without admission of liability and must be completed and returned within 7 days after its receipt.

<table>
<thead>
<tr>
<th>Claim No._____________________</th>
<th>Policy No.__________________________________</th>
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1. Name in Full__________________________________
   Address______________________________________
   Contact Number_______________________________

2. Name of the Bank with address_____________________
   Saving Account No.______________________________

3. A) When did the accident / death occur? State Day, Date and Hour
   B) Where did it occur?
   C) Give full particulars of the cause of death / injuries sustained.

4. Give name and address of the attending Doctors

5. State where and when a Medical or other Officer of the Company can visit you, if necessary.

6. A) In case of Death, Original FIR / Post Mortem Report/ Death Certificate to be attached.
   B) In case of Disability, Disability Certificate from Civil Surgeon to be attached.

I HEREBY DECLARE and warrant the truth of the foregoing particulars in every respect, and I agree that if I have made, or if shall make false or untrue statement, suppression or concealment, my right to compensation shall be absolutely forfeited.

Dated _______________________   Signature___________________________

(Claimant)