



The New India Assurance Company Limited

Regd & Head Office: New India Assurance Building, 87, M.G. Road, Fort, Mumbai - 400 001.

Policy Issuing Office : Bandra Divisional Office 142300
C-6,NCL Business Premises, 1st Floor, Bandra-Kurla Complex, Mumbai 400051.

RuPay CARDHOLDER'S PERSONAL ACCIDENT INSURANCE CLAIM FORM 2025-26

POLICY NUMBER: 14230042240100000687

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

RuPay CARD TYPE [PLATINUM / SELECT CARDS]

NAME OF RUPAY CARDHOLDER

AADHAR NUMBER OF CARDHOLDER

BANK ACCOUNT NUMBER

ACCOUNT OPENING DATE

RUPAY CARD NUMBER

NAME OF NOMINEE [CLAIMANT]

MOBILE NUMBER

EMAIL ID

ADDRESS OF CLAIMANT

DATE AND TIME OF

ACCIDENT

PLACE OF ACCIDENT

BRIEF DESCRIPTION OF ACCIDENT

[MANDATORY IN ENGLISH / HINDI]

IF SPACE IS INSUFFICIENT, PLEASE ATTACH SEPARATE SHEET.

NATURE OF CLAIM

DEATH / DISABLEMENT

ANY OTHER RuPay CARD HELD BY THE SAME PERSON

YES / NO

IF YES PLEASE GIVE DETAILS

I hereby declare that the foregoing statements are made by myself and are true in all respect and that I have not attempted to conceal from the Company anything which it ought to be made acquainted and also that I have not abstained from any usual occupation longer than absolutely necessary and I agree that if I 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 right to compensation forfeited and I am 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 may make in connection with this claim.

BANK SEAL AND
SIGNATURE

SIGNATURE OF
CLAIMANT

WITNESS CERTIFICATE

[TO BE FILLED UP AND SIGNED BY AN EYE WITNESS TO THE ACCIDENT IF ANY]

I hereby certify that I was present when the Accident occurred to Mr./

Ms. _____ on the _____ day of _____ 20 ____ in the manner
stated by him/her over leaf, that it was caused by _____ which * was
/ was not his/her wilful act and that he /she * was / was not under the influence of intoxicating liquor at
the time.

*Strike out which is not applicable

SIGNATURE & DATE

NAME OF WITNESS

ADDRESS

OCCUPATION

MEDICAL CERTIFICATE for DISABILITY CLAIMS ONLY

Disability Claims must be supported by medical evidence furnished by the Insured and at his expense.

NAME OF INJURED PERSON [CLAIMANT]	
SEX : [MALE / FEMALE]	AGE :
NATURE OF ACCIDENT	
WHETHER THE INJURIES ARE CONSISTENT TO THE DESCRIPTION OF ACCIDENT.	
DATE ON WHICH YOU FIRST ATTENDED THE CLAIMANT FOR THE INJURY	
HAS THE CLAIMANT BEEN DISABLED TOTALLY OR PARTIALLY	
IS THE CLAIMANT SUFFERING FROM ANY DISEASE/ ILLNESS/SYMPOTMS APART FROM THE INJURY WHICH MAY TEND TO RETARD RECOVERY? IF YES, PLEASE GIVE DETAILS.	
TYPE OF DISABILITY	

Having personally examined the above named Insured, I certify that the above statements are correct and that the insured person is necessarily disabled by the accident referred to

Signature : _____

Name & Qualification : _____

Address : _____

Date : _____