	CLAIM FORM_MEDICAL INSURANCE	
	THE ORIENTAL INSURANCE CO. LTD. M.C.D.O. 16, Magnet House, 4th floor, N.M. Marg, Ballard Estate, Mumbai 400 001. **Tel. 022-22619241/5154 , fax 022- 22619243.**	
	email: 111700@orientalinsurance.co.in	Dilip.wagal@orientalinsurance.co.in; Shobha.jadhav@orientalinsurance.co.in
1	Name of the Owner :	
2	Claimant i.e. Fleet owner/driver/ Helper cum cleaner :	
3	Whether Claimant is the Owner of the Vehicle :	
4	Customer ID :	
5	Card PAN No. :	
6	Regn. No. of the Vehicle/Vehicles involved :	
7	Date & Time of Accident :	
8	Place of Accident :	
9	Cause of Accident :	
10	Nature of Injury :	
11	Name, Place & Regn. No. of Hospital/ Name & address of attending Doctor :	
12	Amount claimed :	
	Counter signature of Owner of Vehicle, if claimant not the owner	
	Signature of Claimant	