CLAIM FORM MEDICAL INSURANCE

THE ORIENTALINSURANCE CO. lTD. M.C.D.0.16, Magnet House,4th floor, N.M.Marg, Ballard Estate,Mumbai-400 001.
Tel. 022-22619241/5154,fax 022-22619243.

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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	
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