

BAJAJ ALLIANZ GENERAL INSURANCE COMPANY LIMITED**Head Office: GESCO Plaza, Airport Road, Yerawada, Pune 411 006**

Loss of Licence (LoL) and Personal Accident (PA) CLAIM FORM

Policy No.:**Duration of Policy:****Certificate No.:** SNO/BJAZ/**From :** ___ / ___ / ___ **to** ___ / ___ / ___**Claim No.:**

1. **Name of the Insured:**
(In whose name the policy is issued):
2. **Details of the Insured person**
(In respect of whom claim is made):
 - (a) **Name & relationship with the insured:**
 - (b) **Present completed age:**
 - (c) **Occupation:**
 - (d) **Residential Address:**
 - (e) **Aviation licence no:**
 - (f) **Licence Details :**
3. **Nature of disease/illness contracted or Injury suffered :** _____.
4. **Date of injury sustained or Disease/Illness First detected :** _____.

Coverage I : Loss of Licence

- A. **Photocopies of Medical Certificate (CA 35) and DGCA Assessment at the time of taking the policy (Date to be filled):** _____.
- B. **Medical certificate issued by Director General of Civil Aviation for Unfitness/ Letter of Intimation to DGCA by Employers Medical Department Doctor/Medical officer (Date to be filled):** _____.
- C. **Photocopy of Salary Slip / Form 16 at the time of taking the policy.**
- D. **Photocopy of Licence**
- E. **Treatment Details/Discharge card/ other relevant Documents.**
_____.

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Coverage II: Personal Accident Policy

- A. **Nature of Disablement :** _____

- B. **Extent of disablement :** _____

- C. **Present state of incapacity:** _____

- D. **Name and address of Physician/ Surgeon in attendance:** _____

I/We hereby declare that the foregoing statements are true in all respects and that I/We have not attempted to conceal from the company anything with which it ought to be made acquainted and also that if I/We 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/our right to compensation forfeited and am/are 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/We may make in connection with this claim.

Date :

Signature of the Insured/Nominee*

*** : Signature of the nominee is required in case of the Death of the insured**