

## **ADDDB Claim Intimation Form**

Policy No: \_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Life Assured: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Place of Accident: \_\_\_\_\_

Cause of Accident: \_\_\_\_\_

Detailed description of Accident:

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The above statements are true and correct to the best of my knowledge.

**Signature of Claimant:** \_\_\_\_\_ **Dated:** \_\_\_\_\_

**Name of Claimant:** \_\_\_\_\_ **Relation to the Life Assured:** \_\_\_\_\_

**Address:** \_\_\_\_\_

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**Phone Number:** \_\_\_\_\_ **Email id (if any):** \_\_\_\_\_

If the executant is an illiterate (affixing thumb impression) or a person subscribing his/her signature in vernacular then the witness has to attest the thumb impression / Signature and execute the following declaration

Certified that the contents of this Form were explained by me to Mr. /Mrs. /Ms. \_\_\_\_\_  
\_\_\_\_\_ (Insert name) in \_\_\_\_\_ language and that he / she has affixed his/her  
signature/thumb impression thereto in my presence after thoroughly understanding the same. I  
have truthfully recorded the replies given.

Date:

Signature of witness: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

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Phone Number: \_\_\_\_\_

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