প্রাইম ইন্স্যুরেন্স কোম্পানী লিমিটেড
Prime Insurance Company Limited

Head Office : Unique Heights (9th Floor),117,Kazi Nazrul Islam Avenue, Dhaka -1000

অগ্নি দাবীপত্র

(এই দাবীপত্র ইস্যু করাকে বীমাকারীর পক্ষে কোন দায়-দায়িত্ব গ্রহণ করা বুঝায় না)

১। বীমা গ্রহীতার নাম ঃ .....

২। দাবীদারের নাম ঃ .....

৩। বীমা চুক্তিপত্র নং ঃ ..... সময় সীমা ..... হইতে ..... পর্যন্ত

৪। কখন অগ্নি / দাঙ্গা জনিত অগ্নি / ঘূর্ণিবার্তা / বন্যা / ভূমিকম্প ইত্যাদি সংঘটিত হইয়াছিল?	সময় ..... দিনে/রাত্রে তারিখ .....
৫। কি ধরনের ঝুকি বীমা চুক্তিপত্রে আওতাভুক্ত ছিল? (দায় বহির্ভূত ঝুকি কাটিয়া ফেলুন)	(১) অগ্নি (২) দাঙ্গা জনিত অগ্নি (৩) দাঙ্গা, হরতাল জনিত ক্ষতি (৪) ঘূর্ণিবার্তা (৫) বন্যা (৬) ভূমিকম্প।
৬। অগ্নির কারন কি দাঙ্গা জনিত অগ্নি / দাঙ্গা / হরতাল প্রণিত ক্ষতি / ঘূর্ণিবার্তা / ভূমিকম্প? উহা কিভাবে সংঘটিত হইয়াছে।	
৭। (ক) ক্ষতিগ্রস্ত সম্পত্তির অবস্থান? (খ) তৈরীর সন	
৮। ক্ষতিগ্রস্ত ঘর-বাড়ীর নির্মানের ধরণ কি?	(ক) দেয়াল ..... (খ) ছাদ .....
৯। কিভাবে বীমাকৃত ঘর-বাড়ী ব্যবহৃত হইতেছিল?	
১০। দূর্ঘটনার পূর্বে ক্ষতিগ্রস্ত সম্পত্তি কি বীমা চুক্তিপত্রের বর্ণনার সহিত সম্পূর্ণ সম্পর্কযুক্ত ছিল ?	
১১। বীমা চুক্তিপত্রে প্রস্তাবের পর কোন নতুন ধরণের ঝুকি প্রবর্তন করা হইয়া ছিল কি না?	
১২। বীমা চুক্তিপত্রের সকল শর্তাবলী যথাযথভাবে পালন করা হইয়াছে কি না?	
১৩। ক্ষতিগ্রস্ত সম্পত্তিতে দাবীদার কি ভাবে অস্তিত্বান?	(১) মালিক। (২) যৌথ মালিক। (৩) ইজারাদাতা। (৪) ইজারদার। (৫) বন্ধকদাতা। (৬) বন্ধক গ্রহীতা।

আমি/আমরা, বর্তমানে .....

ঠিকানায় অবস্থানরত, এতদ্বারা ঘোষণা করিতেছি যে, উপরোল্লিখিত বিষয়সমূহ একটি পূর্ণাঙ্গ, সত্য এবং নির্ভুল ঘোষণাপত্র এবং আমি / আমরা আরও ঘোষণা করিতেছি যে, অপর পৃষ্ঠায় উল্লিখিত দ্রব্যাদি আমার / আমাদের মালিকানায় থাকা অবস্থায় এবং উপরোদ্ধৃত বীমা পলিসি বা পলিসি সমূহের অধীনে সীমাবদ্ধ থাকা অবস্থায় ঐ সকল দ্রব্যাদি উপরোক্ত অগ্নিকান্ডে আকস্মিক দূর্ঘটনাজনিত কারণে বিনষ্ট হইয়াছে বা ক্ষতিগ্রস্ত হইয়াছে যাহাতে আমার / আমাদের কোন অভিসন্ধি বা হাত ছিল না এবং যাহার পরিমাণ মূল্য এই সঙ্গে সংযুক্ত করা গেল। অতএব আমি / আমরা ঐ ক্ষতির সংকস্বরূপ প্রাইম ইন্স্যুরেন্স কোম্পানীর নিকট ..... টাকা দাবী করিলাম।

আমি/আমরা স্বশ্রদ্ধচিত্তে ঘোষণা করিতেছি যে, আমি / আমরা উক্ত অগ্নিকান্ডের দরুন কোনরূপ প্রবঞ্চনা বা ইচ্ছাকৃত মিথ্যা বর্ণনা বা অনুদঘাটন করিয়া অসংগতভাবে লাভবান হইবার চেষ্টা করি নাই। এই পবিত্র ঘোষণাপত্র বিবেকের নিকট সত্য বলিয়া বিশ্বাস করিয়া আমি / আমরা এই ঘোষণাপত্র দিলাম।

..... সালের .....মাসের .....তারিখে স্বাক্ষরিত হইল।

(দাবীদারের স্বাক্ষর)

অপর পৃষ্ঠায় দ্রষ্টব্য

ক্ষতিগ্রস্ত সম্পত্তির পূর্ণ বিবরণ

বীমা চুক্তি পত্র নং	বীমা চুক্তি পত্রের দফা নং	সম্পত্তির বিবরণ	বীমাকৃত মূল্য	ক্ষতিগ্রস্ত সম্পত্তির মূল্য	উদ্ধারকৃত সম্পত্তির মূল্য	উদ্ধারকৃত সম্পত্তির মূল্য বাদে দাবীর অংক	মেরামতের খরচ

যেহেতু অগ্নিবীমা একটি ক্ষতি পূরণের চুক্তি মাত্র, অতএব অগ্নিকান্ডের সময় দ্রব্যাদির যে প্রকৃত মূল্য ছিল উহাই সকল দাবীর ভিত্তি হইবে। দাবীর ভিতর কোন প্রকার ব্যবসার লাভ অন্তর্ভূক্ত করা যাইবে না।

(দাবীদারের স্বাক্ষর)

প্রাইম ইন্স্যুরেন্স কোম্পানী লিমিটেড
Prime Insurance Company Limited

Head Office : Unique Heights (9th Floor), 117, Kazi Nazrul Islam, Avenue, Dhaka-1000

MOTOR CLAIM FORM

(THE ISSUE OF THIS FORM IS NOT BE TAKEN AS AN ADMISSION OF LIABILITY BY THE INSURER)

"Please do not give any Third Party any information or particulars which you are not required by law to give and in no case admit your foult or make any payment or offer of payment without the written authority of the Company"

Answer all questions fully. It will help avoid unnecessary correspondence and consequent delay in the settlement of Claim.

1. Name of Insured (in full) _____
2. Address _____
3. Occupation _____
4. Certificate/Policy No. _____
5. The Insured Vehicle
   - (a) Make _____ (b) Horse Power _____ (c) Registration No. _____
   - (d) Price Paid by the Insured _____ (e) Year of manufacture _____
   - (f) Sum Insured _____
   - (g) Purpose for which it was being used at time of accident _____
   - (h) Was it in proper order and condition at the time ? _____
   - (i) Was it being used with your knowledge and consent ? _____
   - (j) If the claim is in respect of a Motor Cycle state whether a Pillion passenger was being carried at the time of accident _____
   - (k) If the claim is in respect of a Lorry, state whether a trailer was attached _____

6. **The person driving at the time of accident.**
   - (a) Full name of the person _____
   - (b) His address _____
   - (c) His age _____ (d) Is he your permanent paid driver ? _____
   - (e) Date and number of Licence _____ (f) Was it in force at the time of accident ? _____
   - (g) Has it ever been endorsed or suspended. If so, give full details with dates _____
   - (h) Is he entitled to indemnity under any other Company's Policy ? _____
   - (i) Was he sober ? _____
   - (j) Expiry date of Driving Licence _____

7. The Accident (Damage, Fire, Theft)

(a) Date of Occurence _____ (b) Time _____

(c) Place (Street or Road And Town) _____

(d) Were you in the vehicle ? _____ (e) If not, when was it reported to you ? _____

(f) On what side of the street or road was your vehicle and how far from the kerb ? _____

(g) What was the width of the street or road ? _____

(h) At what speed was the vehicle being driven before the accident ? _____

(i) And at what speed was it beng driven at the time of the accident _____

(j) Give full details of the nature and cause of the $\frac{\text{Accident}}{\text{Theft}}{\text{Fire}}$

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(k) If possible draw a sketch of the scene of accident.

_____

8. The Damage

(a) Give in detail the extent of all damages to the insured vehicle directly due to the accident

_____

_____

_____

_____

_____

_____

(b) Estimated cost of repairs Tk. _____

(c) Where can the vehicle be inspected ? _____

(d) Have you given instructions for repairs to be carried out ? If so, to whom (Name & Address)

_____

(e) Have you instructed them to send an estimate to the Company immediately ?

N.B If possible an estimate of repairs should be attached to this form and in any event it must be sent to the Company without undue delay. The fact that estimate is for Tk. 300.00 or below does not exempt the insured from the obligation to forward an estimate forthwith.

9. The Result

(a) Has the accident caused any injury to any person or persons ?
If so, give the following particulars :

Name	Address	Occupation	Nature of injuries	Whether being conveyed in the vehicle or not

(b) If any injured person has been removed to any Hospital or medically attended give name and address of the Hospital or doctor _____

_____

(c) Did the accident cause damage to property or livestock ? If so, give name and address of the owner stating nature and extent of damage _____

_____

_____

_____

_____

10. General

(a) Has any claim been made upon you by any third Party ? If so, give details and attach the intimation.

(b) If accident was caused by the fault of any third Party, give name and address of such person (s).

(c) How many persons were in the vehicle at the time of accident ?

(d) Give the following particulars about all witnesses to the accident :

Name	Address	Whether being conveyed in the vehicle or not

(e) Was the matter reported to the Police ? If so, give name of the Police Station

(f) What action, if any, has been or is being taken by the Police or any other authority ?

(g) Give particulars of other insurance on the vehicle, if any

I/We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect and I/We agree that if I/We have made, or in any further declaration the Company require in respect of the said accident shall make any false or fraudulent statement or any supperssion or concealment the Policy shall be void and all rights to recover thereunder in respect of past or future accident shall be forfeited

Date

Signature with seal

Witness

PRIME INSURANCE COMPANY LIMITED

Head Office: Unique Heights (9TH FLOOR),
117, Kazi Nazrul Islam Avenue, Dhaka.

ALL RISK CLAIM FORM

Name of the Insured : _____

Name of the Claimant: _____

Insurance Policy No : _____

Period Covers : _____

When does the accident take place?	
State nature and cause of the accident	
The location of the affected property	
The purchase price of the damaged property	
Did you consult with any repairer?	
Does the damaged property require repair or replacement?	
What would be the cost of repair or replacement?	
Whether the conditions of the policy have been complied with?	

I declare the information furnished above is true.

Signature and date of the claimant

PRIME INSURANCE CO. LTD.
HEAD OFFICE, DHAKA.
CLAIMS DEPTT

DREAD DISEASE CLAIM FORM

(Issuance of this form does not imply admission of liability by the insurer)

01. Name of Insured :

02. Policy No. :

03. Period : From ---------- To ----------

04. Depositor's Name, Address & Last Occupation :

05. Deposited Amount with date : Tk.

06. Name of Deposited Branch :

07. Date of Birth of Depositor :

08. Direct Cause of Death :

09. Place of Death :

10. Date of Death :

11. Name of Claimant :

12. Name of Nominee (s) :

13. How Long the depositor suffered from the disease which caused his/her death. :

14. Date and Name of Hospital/ Clinic of last admission of the depositor :

15. Date of admission into Hospital/Clinic :

16. Name & Address of Last attending Physician :

17. Please attach copies of prescription for last two years before his/her death :

I/we hereby declare that we have furnished full informations against the above questions. The informations as furnished above are correct. If it is found that I/We have made fraudulent or suppression or concealment of facts relating to the death of the Depositor, all of my/our rights of recovery of claim from the Insurer will be forfeited.

Countersignature of the Branch Manager

Date :

Signature of the Nominee(s)

Date :

Prime Insurance Company Ltd.

Unique Heights (9th Floor)
117, Kazi Nazrul Islam Avenue, Dhaka-1000

GROUP CLAIM FORM

Issuance of this form does not amount to admission of any liability of under the policy on the part of the insurers. Please give the following information correctly and completely to enable us process your claim promptly.

All dates to be entered as Date / Month / Year

Employee ID No.:

1.Name of the Insured:
(in whose name 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) Bank Details (i) Account No _____
   (ii) Name of the Bank _____
   (iii) Branch _____

3. Policy Number (in Full) : _____
4. Nature of Disease/Illness contracted or injury sustained _____
5. Date on which injury was sustained/Disease
   Or illness first detected : _____
6. (a) Name and Address of the attending : _____
   Medical Practitioner : _____
   _____
   _____
   (b) Qualification & Telephone No. : _____
   (c) Registration No. : _____
   (d) Name & Address of the Hospital/Nursing

Home / Clinic :_____

_____

_____

(e) Date of Admission :_____

(f) Date of Discharge :_____

7. Are you at present covered under any other similar type of scheme like P.A. Cancer Insurance, Mediclaim (Individual or Group), Health Insurance, etc. If Yes. Please give particulars of each

Sr. No.	Contents	Details
	Name of Insurer Insurance Scheme Policy No. Period of cover Claim Amt. Recd./receivable	

(a) Is this the first year of coverage under health Insurance Policy? Yes / No.

If no, since when have you been continuously insured under Health Insurance Policy. Give details

Year	Insurer	Policy No.

(b) (i) Is this the first claim under this policy ? Yes/No

(ii) If no, please quote Previous claim number and details

Year	Policy No.	Insurer	Disease/Ailment/Injury details	Amount claimed and receivable or received

In support of the above claim, I enclose the following original documents (Please indicate)

1. Bill, Receipt and Discharge certificate / card from the Hospital.
2. Cash Memos from the Hospitals (s) / Chemists (s), supported by proper prescriptions.
3. Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests.
4. Surgeon's certificate stating nature of operation performed and Surgeons' bill and receipt.
5. Attending Doctor's/ Consultant's/ Specialist's / Anesthetist's bill and receipt, and certificate regarding diagnosis.
6. Certificate from attending Medical Practitioner / Surgeon that the patient is fully cured.

Summary of expenses incurred for which original bills / receipts / cash memos are enclosed.

Total of Hospital Bill	Tks. _____
Consultant's /Surgeon's /Anesthetist's Fees	Tks.. _____
Diagnostics Tests	Tks. _____
Medicines purchased from chemists	Tks. _____
Other expenses not included above	Tks. _____
Grand Total	Tks. _____

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance.

Dated at..... this..... day of.....

_____

Signature of the Claimant

প্রাইম ইন্স্যুরেন্স কোম্পানী লিমিটেড
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Head Office : Unique Heights (9th Floor),117,Kazi Nazrul Islam Avenue, Dhaka -1000

BURGLARY CLAIM FORM

(The issue of this claim form is not to be taken as an admission of liability by the Insurers.)

The Insured .....

The Claimant.....

Claim under policy No.....

Policy Validity .....

1. Address of the premises which the loss sustained	
2. (a) When was the loss discovered? (b) By whom was it discovered? (c) Were any witnesses present ât the time of the discovery? if so, please state their names and addresses	(a) (b) (c)
3. Give the date of informing the police of police station (The police must be informed promptly in all cases)	
4. Which rooms were rifted?	
5. How were the premises centered?	
6. (a) Were the premises occupied at the time of the loss? (b) If not, on what date and at what hour wre they last occupied? (c) Was the insured Property guarded by an appointed guard?	(a) (b) (c)
7. Do you suspect any person or persons? If so, please state the parties in mind	
8. (a) Are you the sole owner of the property for which the claim is made? (b) If not, give details of other interested parties.	(a) (b)
9. Are there any other insurances against theft /Burglary upon the same property?	
10. What was the total value of the contents of your premises at the time of the loss?	
11. Have you ever before sustained loss by Fire, Burglary, House Breaking, Larceny? Was a claim made upon any Insurers? If so state name, date nature of loss and amount paid.	

I/We declare that above is a full and accurate statement, and 1/We therefore claim the sum of Tk. ... ... as the amount due to me/us in respect of the loss of property detailed overleaf.

Date... ... ... Signature of Insured... ... ...

INSTRUCTIONS FOR COMPLETION OF THIS FORM

(a) The form must be fully completed and sent to the company or its loss Adjusters within seven days of the discovery of the loss:

(b) Stock claims should show actual cost of manufacture or invoice cost, less discounts, Selling prices should NOT be claimed.

(c) If any goods are included in a hire purchase contract they must be declared separately.

(Please See overleaf)

(1) Description of property in respect of which this claim is made	(2) Date when bought or received	(3) Where bought or, if a present, Name and Address of giver	(4) Cost price (less Discounts)		(5) Value at time of loss after allowing for wear and tear		(6) Net amount claimed		(6) Remarks.

Date .....

If necessary, please continue on a separate sheet.

Signature of Insured.

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CLAIM FORM FOR MBD / CAR / EAR / CPM / EEI INSURANCE

(The issue of this form is not to be taken as an admission of liability by the Insurers.)

1. (i) Policy/Cover Note No. :
   (ii) Name of Insured & Address :

   (iii) Address of Site :
   (iv) Name of Supervising Engineer :
   (v) Nearest railway station :
   (vi) Advisable approach route to site from station or otherwise :

2. Sum Insured :
   Does the sum insured represent the replacement value? :

3. What is the depreciation cost if the sum insured does not represent the replacement value?

4. When did the loss/damage occur? :
   (state date & exact time)

5. Give name & address of witnesses to the occurrence. :

6. Which items & parts were damaged :
   (Give your order number & manufacture's name, number, type, size, capacity, weight, pressure, etc.)

7. Whether the machinery was in motion or stationary at the time of loss. :

8. How did the damage occur and what was its probale cause? :
   (Please attach sketches, photos, STG continue under 15, if space not sufficient).

9. Does the breakdown show any sign of faulty casting or faulty material or of previous repair? :

10. State the year of manufacture of each machine / plant / equipment

Contd. to Page 2

11. How will the damaged items be repaired and by whom?

12. Is replacement necessary? :

13. Will any alteration or improvement be made to design, construction or material when repairs are carried out? :

14. What are the estimated costs for the repair of damage to machinery? :

15. Is public liability involved? :
(Give details regarding property).

16. REMARKS

I/We declare that we have answered all the above questions truthfully, conscientiously and nothing has been concealed and no fraudulent statement has been made.

Dated at_____ this_____day of_____

Signature with rubber stamp
of the mortgagor / principal

Signature with rubber stamp
of the mortgagee / contractor.

প্রাইম ইন্স্যুরেন্স কোম্পানী লিমিটেড
Prime Insurance Company Limited

Head Office : Unique Heights (9th Floor),117,Kazi Nazrul Islam Avenue, Dhaka -1000

PERSONAL ACCIDENT CLAIM FORM

This form should be completed and returned within seven days of its receipt by the Insured.

PARTICULARS OF CLAIM

Name of Insured in full _____

Private Address _____

Business Address _____

Profession or Occupation _____ Present age _____ years.

Policy No. _____ Date of payment of last premium _____

1. State when and where the Accident took place — Date _____ Time _____ am/pm Place _____
2. State how it happened and what you were doing at the time. (It is necessary that the fullest details be given) _____
3. State (a) What injuries you have sustained. _____
   (b) Whether you have ever had an injury to the same part before _____
4. Are you insured elsewher against Accidents ? _____
   If so, given particulars _____
5. Give the Names and address of any Witnesses of the Accident. _____
6. Give the name and address of the Medical Man who attended you on your meeting with the accident. _____
   Is he your usual Medical Attendant ? _____
   Has he, or any other Medical Man, attended you during the last five years for any illness or injury ? _____
   If so, give particulars. _____
7. Have you, as the direct result of the Accident, been totally incapacitated from attending to business of any kind ? If so, state for how long. From _____ To _____
8. Are you still totally incapable of attending to business of any kind. From _____ To _____
9. State if (a) Confined to bed From _____ To _____
   (b) Confined to house
   (c) Able to get out of doors
10. If now able to attend to any portion whatever of your business or occupation, state when you commenced to do so. _____
11. Have you fully resumed your usual business or occupation ? If so, since when. _____
12. When & where can you be visited by our Medical or other Officer ? _____
    Name nearest Railways Station & distance therefrom. _____
13. If you are prepared to agree to an immediate settlement please state the amount you are willing to accept. _____

I HEREBY WARRANT the truth of the foregoing statements

Dated _____ 19 Signature _____

No. Claim can be entertained without the certificate of a duly qualified and registered medical practitioner.

FORM-B

MEDICAL CERTIFICATE

(To be completed and signed by attending physician)

01. Name of claimant ----------

02. So far as you are aware, how did the injury arise? ----------

03. When did he first Consult you in connection with the accident ----------

04. Are you still in attendance? ----------

05. Are you the usual Medical attendant? If so, how long have you known to him? ----------

06. Please state fully the nature of the injuries sustained (If it is a limp or eye injured stated whether right or left) ----------

07. Are the symptoms from which he suffers due to the accident alone? ----------

08. Is the Claimant suffering from any disease in addition to the present injuries or has he any physical defect? ----------

09. State if the claimant by your advice is :

    a) Confined to bed ----------

    b) Confined to house ----------

    c) Able to get out of doors ----------

10. If the claimant is in your opinion unable to give any attention to his profession or occupation, as described on the front page, please state ----------
    Date of commencement of total disablement probable future duration. ----------

11. In the event of the claimant being able to give partial attention to such profession or occupation please state ----------

    Date of commencement of partial disablement probable future duration ----------

12. If recovered please state date of recovery ----------

13. General remarks ----------

I certify that to the best of my belief the foregoing statements are correct

Signature of attending physician ----------

Address

C

PERSONAL ACCIDENT CLAIM FORM

(To be completed and signed by injured employee)

(Supplementary)

01. Name and Present Address ----------

02. Date of last medical attendance ----------

03. State how long you have been

    a. Confined to house From ---------- to ----------

    b. Able to get out of doors. From ---------- to ----------

4. How long have you been

    a. Totally disabled From ---------- to ----------

    b. Partially disabled From ---------- to ----------

5. If you are prepared to agree to an immediate settlement please state the amount you are willing to accept. ----------

I HEREBY WARRANT THE TRUTH TO THE FOREGOING STATEMENT

Signature ----------

Date ----------

D

MEDICAL CERTIFICATE

(To be completed and signed by attending physician)

01. Are you still attending the Claimant? ----------

02. What are his present symptoms? ----------

03. How long has be he been

    a. Totally disabled From ---------- To ----------

    b. Partially disabled From ---------- To----------

04. How much longer is it probable that the claimant's present state of disability will continue

5. GENERAL REMARKS ----------

I CERTIFY that to the best of my belief the foregoing statements are correct.

Signature ----------

Qualification ----------

Dated ----------

Address ----------