Accidental Injury Claim
Claimant's Statement

Form 'A'

INSURED INFORMATION

Insured's Name_________________________________ Date of Birth ___/____/____ Marital Status ____

Insured's Address ____ Phone No. (Off)________________________

____ Phone No. (Res)______________

Name and address of employer ____

Policy Number ________________________ Insured's Occupation ____

Does the insured have any other insurance ? _________If yes, please list all companies, type of insurance, policy numbers and insurance amounts:____

____

CLAIM INFORMATION

Date of accident _____/_______/_______ Time and place accident occurred____

Please describe in detail the circumstances of accident (attach separate sheet if needed): ____

____

Was the accident related to the Insured's occupation? __________________ If so, how? _______________________________________

Please describe the nature of Insured's injuries:____

Please list the names and addresses of all treating physicians and hospitals:____

____

____

Did police or other authorities investigate the accident? ____ If yes, please provide name, address and telephone number of all investigating officers and agencies: ____

CLAIMANT INFORMATION (If different than "Insured Information" above)

Claimant's Name____ Age_______ Relationship to Insured______________

Claimant's Address____ Phone No. (Off) _______________________

____ Phone No. (Res)_______________________

In what capacity are you making this claim? ____

AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by HDFC ERGO General Insurance, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.
SIGNED (Claimant or authorized person) ____ DATE ____/____/____

Accidental Medical Expense

Insured's Statement

Form 'B'

INSURED INFORMATION

Insured's Name____

Insured's Address____ **Phone No. (Off)**_______________________

____ **Phone No. (Res)**_______________________

Policy Number ______________________

CLAIM INFORMATION

Date of accident _____/_______/_______ **Time and place accident occurred**_______________________________________

Please describe in detail the circumstances of accident (attach separate sheet if needed): _______________________________________

____

Was the accident related to the Insured's occupation? __________________ **If so, how?** _______________________________________

Please describe the nature of Insured's injuries:____

Did police or other authorities investigate the accident? ____ **If yes, please provide name, address and telephone number of all investigating officers and agencies:** ____

Please list the names and addresses of all treating/consulting physicians or other healthcare providers:

Name **Street Address** **City** **State** **Pin Code** **Phone**

____

____

If hospitalized, please provide name and address of hospital(s) where treatment was received:

____

Do you have any other insurance that may provide coverage for this accident or loss? _____ **If yes, please identify name, address, and policy number of all other insurance:** ____

____

AUTHORIZATION

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Signed (Insured or authorized person) ____ **Date** ____/____/____

CERTIFICATION OF NO OTHER INSURANCE

I, _________________________________**hereby certify that I have no other accident or health insurance or any other insurance covering this loss.**

Signed (Insured or authorized person) ____ **Dated** _____/_____/_____

Hospital Cash Plan Claim Form

Form 'C'

(N.B. To be filled in by the Insured Policyholder, or Insured's authorised representative enjoying power of attorney. Issuance of this claim form is not be taken as admission of liability)

PART I – Insured Information

Name of Policyholder :

Name of Employee/Member :
(For group insurance policy only)

Policy No. :

Insured No./Certificate No. (If applicable 倘適用) :

Name of Patient:

I.D. Card No. :

Occupation :

Date of Birth :

Relationship to the Policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Staff/Member ☐ Dependent

(1) Have you had any prior treatment for this or related conditions?

NO ☐ YES ☐ Doctor's Name : ______________________

Address : ______________________

____

Date(s) : ______________________

(2) Are you making any other insurance claim as a result of this hospitalization/surgery?

NO ☐ YES ☐ Name of Insurance Company : ______________________

Policy No. : ______________________

(3) (a) Was the hospitalization/surgery a result of an accident?
NO ☐ YES ☐ ____________

(3) (b) Date of accident ______/_______/______ Time and place accident occurred______________________

Please describe in detail the circumstances of accident (attach separate sheet if needed):

4) Hospitalization
Name of hospital : ______________________

Date of admission: ________ Date of Discharge : ____________________

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

AUTHORISATION

I HEREBY AUTHORISE on behalf of the patient: (1) Any employer, medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organisation, institution or person, that has any records or knowledge of the patient and/or who has attended or may hereafter attend the patient to disclose such information to HDFC ERGO General Insurance Company; (2) HDFC ERGO General Insurance Company or any of its appointed medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of the patient in relation to this claim. This authorisation shall bind the patient's successors and remains valid notwithstanding death or incapacity. A photocopy of this authorisation shall be as valid as the original.

____________________ ____________________

Date Signature of Patient

Place:

Accidental Injury
Hospital Cash Claim (Accident or Sickness)
Attending Physician's Statement

Form 'D'

INSURED INFORMATION

Insured's Name_________________________________ **Date of Birth** ____/____/___ **Marital Status** _____

Insured's Address____ **Phone No. (H)**_________________________

____ **Phone No. (W)**________________________

Name and address of employer ____

Policy Number______________________________ **Insured's Occupation** ____

CLAIM INFORMATION

Date of accident: ____/ ____/____ **Date of first treatment:** _____/_____/_____

Please describe in detail the nature of the Insured's injuries,
____
____

Was the accident related to the Insured's occupation? ___________________ **If so, how?** ____

Was the Insured hospitalized? _______ **If yes, please list the names and addresses of all hospitals and all admission/discharge dates:**
____
____

Did the Insured have any injury or illness prior to the accident that contributed to the accident or to the Insured's present condition? ____
If yes, please describe: ____
____

Were any surgical procedures performed? ______ **If yes, please list all procedures, and dates performed:**
____
____

What are the Insured's current subjective symptoms? ____
____

What are the objective findings? (please include results of current x-rays, lab tests, etc.,)? ____
____

Dates of total disability: **Dates of partial disability:**

From: _____/_____/_____ **To:** ____/____/____ **From:** _____/_____/______ **To:** _____/_____/_____

Date Insured able to return to work: _____/_____/_____

Was the Insured seen by any other physician? ______ **If yes, please list the names and addresses of all other physicians:** ________________
____

ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician: ____ **Phone No.** ________________________

Address: ____

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Attending Physician) ____ **DATE** ____/____/____

Form ‘E’

Accidental Death

Claimant’s Statement

INSURED INFORMATION

Insured’s Name_________________________________ Date of Birth ___/____/____ Marital Status _____

Insured’s Address ____

Name and address of Last Employer
____

Policy Number ________________________ Insured’s Occupation (at time of death) _________________

Did the Insured have any other accident or life insurance? ________ If yes, please list all companies, policy numbers and insurance amounts:__ ____

CLAIM INFORMATION

Date of accident _____/______/_____ Time and place accident occurred_____________________________________

Please describe in detail the circumstances of accident (attach separate sheet if needed):

____

____

Was the accident related to the Insured’s occupation? _________________ If so, how? _________________________

Please describe the cause of the Insured’s death:
____

Please list the names and addresses of all treating physicians and hospitals:_____________________________________

____

Did police or other authorities investigate the accident? ____ If yes, please provide name, address and telephone number of all investigating officers and agencies: ____

Was an autopsy performed?_____ If yes, please provide name and address of Medical Examiner__________________

____

Was a coroner’s inquest held? ______If yes, what was the determination?____________________________________

CLAIMANT INFORMATION

Claimant’s Name_______________________________________ Age______ Relationship to Insured_____________

Claimant’s Address____ Phone No. (H)__________________________

____ Phone No. (W)__________________________

In what capacity are you making this claim? _____ Beneficiary ______ Executor* ______ Administrator* _____ Guardian* _____Trustee* _____Assignee*

*Please provide a certified copy of all documents supporting your authority (e.g., Succession Certificate, Notarised Affidavit, Notarised will, etc.)

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by HDFC ERGO General Insurance, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Place:

DATE ____/____/____

____
SIGNED (Claimant or authorized person)