



PARIVAR SURAKSHA BIMA – SECTION I
Claimant's Statement

INSURED INFORMATION

Insured's Name _____ Date of Birth ___/___/___ Marital Status _____

Insured's Address

Policy Number _____ Insured's Occupation (at time of death)

Certificate Number _____ Membership
Number _____

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

ACCIDENT 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 list the names and addresses of all treating physicians and
hospitals: _____

Date of Admission: _____ Date of Discharge: _____

Hospitalisation Expenses: _____



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

CLAIM INFORMATION FOR DEATH

Please describe the cause of the Insured's death:

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? _____

CLAIM INFORMATION FOR DISABILITY

Nature of Injuries: _____

Has the Accident resulted into Loss of Hand / Hands or Loss of Foot / Feet / Eye / Eyes / Permanent Total Disability of any other type which may prevent the Insured Person engaging in or being occupied with or giving attention to any employment or occupation whatsoever? If yes, please list details

Please also attach the Certificates & Reports from the Hospital Authorities or Attending Civil Surgeons certifying the Permanent Total Disablement.



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 Chubb General Insurance Co. Ltd., 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 and I agree that if I 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 hereunder in respect of past or future claims shall be forfeited.

Place:

DATE ___/___/___

SIGNED (Claimant or authorized person)

This is to certify that the above mentioned claim lodged by the Insured Person / Claimant is genuine and the same is recommended for reimbursement.

Authorised Signatory

Place:

Name of the Policyholder & Seal:

Date:



PARIVAR SURAKSHA BIMA – SECTION II

(N.B. To be filled in by the Insured, or Insured’s authorised representative enjoying power of attorney.
Issuance of this claim form is not be taken as admission of liability under the policy on the part of the insurer)

PART I – Insured’s Information

Name of Policyholder:	
Name of Member of Insured Family :	Policy No. _____
Membership No.: _____ Certificate No. _____ (If applicable)	

PART II – Claimant Information

Name of Patient:	I.D. Card No.:
Occupation :	Date of Birth: Present completed age: ____
Address and phone number :	
Relationship to the Policyholder:	<input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Dependent Mother <input type="checkbox"/> Dependent Father
(1) Nature of sickness /disease/injury claimed for :	

Date on which Injury was sustained or disease or illness first detected : _____	
Date of first consultation : _____	
Name, Address, Telephone No. of Doctor Consulted : _____	
Qualification of the Doctor Consulted : _____	
(2) Have you had any prior treatment for this or related conditions?	
NO <input type="checkbox"/> YES <input type="checkbox"/>	Doctor’s Name : _____
	Qualification : _____
	Address & Telephone: _____

	Date(s) : _____
(3) Are you making any other insurance claim as a result of this hospitalization/surgery?	
NO <input type="checkbox"/> YES <input type="checkbox"/>	Name of Insurance Company : _____
	Policy No. : _____



(4) Was the hospitalization/surgery a result of an accident?
 NO YES Place of Accident _____ Date of Accident _____

(5) Is the claim is for Maternity Expense Benefit: NO YES
 If so, is it your first delivery second delivery third delivery
 Are you already having 2 children: NO YES

(6) Details of hospitalisation

Name of Hospital / Nursing Home	Address	Date of Admission	Date of Discharge

(7) CLAIM QUANTUM

Date	Nature of expenses incurred	Billed By	Amount (Rs)
		Total	

(If space is insufficient, please attach separate list)



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

- Hospital Discharge Card
- Bills, Cash Memos, Receipt from Hospitals
- Cash Memos, Receipts from Pharmacists, Pathology and Investigation Centres
- Bills, Cash Memos, Receipts from Attending Doctors, Surgeons, Anesthetists
- Doctor's prescriptions for medicines, pathological tests, hospitalisation, surgery, physiotherapy
- Any other documents. Please specify

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 that 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 Chubb General Insurance Company; (2) HDFC Chubb 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 or facsimile copy of this authorisation shall be as valid as the original.

Date:

Signature of Patient

Place:

This is to certify that the above mentioned claim lodged by the Insured / Claimant is genuine and the same is recommended for reimbursement.

Authorised Signatory

Place:

Name of the Policyholder & Seal:

Date:



ATTENDING PHYSICIAN INFORMATION

<p>Name of Attending Physician: _____ Phone No. _____</p> <p>Address: _____</p> <p>I certify that the above named patient _____, was seen by me on _____ and has been fully cured of the sickness/injury claimed for, which first incurred on _____</p> <p>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.</p> <p>SIGNED (Attending Physician) _____ DATE _____</p> <p>____/____/____</p>
