

GROUP PERSONAL ACCIDENT CLAIM FORM

Claimant's State	ment																												F	For	m'	A'
							- II	NSUI	RED	IN	FO	RM.	ATI	ON																		
Insured's Name:																																
Insured's Address:																																
Date of Birth:	D D	M M	YY	YY		M	1arita	al Sta	ıtus:			Ма	rrie	d			Un	ma	rrie	d												
Phone No. (Off):										Р	hor	ne N	lo.(F	Res):																	
Name and																						\Box					\prod		I		\perp	
address of employer:																											\perp		L			\Box
Policy Number:								-	Ins	sure	ed's	s Oc	ccup	atio	n:											Ш				Ш		
Does the insured have					Ye		Ļ	No											_	_		_			_		_	_	_			_
If yes, please list all co	ompanies,	type of	finsur	ance,	policy	y nu	mbe	rs ar	id in	sur	anc	ce a	moı	unts	i:							=										
							C	LAII	VI IN	FΟ	RM	IAT	ION																			
Date of accident:	D D N	и м	YY	YY	Ti	me :	and	place	e aco	cide	ent o	occ	urre	d:			T		T			\equiv			T		Ŧ	T	T	$\overline{\Box}$		_
Please describe in det	ail the circ	cumsta	nces c	of accid																Ť		一		Ť	T	П	一	Ť	Ŧ	П	$\overline{}$	_
						Ť	Ť		$^{+}$			\exists	Ť	Ť	T		$\overline{}$	$\overline{}$	Ť	Ť			(at	tacl	h se	par	ate	she	et i	f ne	ede	d)
Was the accident relat	ed to the	Insured	d's occ	upatio	n?	Ė	Ye	s		No	 o	lf :	so, l	how	?			Ť	Ť	Ť		$\overline{}$			\top	П	$\overline{}$	\top	\top			,
				- Fatio		_			_				T		T	П	_	_	+	+		\exists			\pm	П	\pm	\pm	+	П	$\overline{}$	ī
Please describe the na	ature of In	sured's	s injuri	es:		$\overline{}$	Ť			П			Ť	Ť	T	П	T	$\overline{}$	Ť	Ť		寸	\pm	Ť	Ħ	П	Ť	Ť	Ť	П	Ħ	ī
Please list the names	and addre	esses o	of all tre	eating	phys	iciar	ns ai	nd ho	spit	als:			Ť	Ť					Ť	Ť		T			T		Ŧ	Ť	Ť	$\overline{\Box}$		ī
									İ					Ì						Ì				Ĺ	Ī			Ī	Ī			
																									\perp		\Box		\perp			
Did police or other aut	horities in	vestiga	ate the	accide	ent?		Ye	s		No)																					
If yes, please provide	name, ado	dress a	and tele	ephone	e nun	nbei	r of a	all inv	esti	aati	ina	offic	cers	an	d ad	gen	cies	s: [_	_				Т	\top		_	_	\top			
yee, predee previde									T		9							,, 	\pm	$^{+}$	\Box	\mp	+	$^{+}$	÷	Н	\mp	\pm	\pm	Н	$\overline{}$	ī
													"																			
Olaina an Ba Nama		С	LAIMA	ANTI	NFOR	AMI	TIO	N (If	diffe	erei	nt t	har	ı "Ir	ısuı	red	Into	orm	iati	on'	' ab	ove)							_			
Claimant's Name:						_	+						\pm	+	_		_	_	\pm	+		_	+	+	\pm	Ш	+	\pm	\pm	Ш	\pm	4
Claimant's Address:						+	$\frac{\perp}{\parallel}$		+	Н			\pm	+			\pm	\pm	\pm	+		\pm	+	+	\pm	Н	\pm	+	\pm	H	\pm	爿
Relationship to Insure	d:		$\dashv \dashv$			\perp	1		Age	. [Т	Yr	'S				F	⊢ Pho	ne	Nο.	(Off	— ე: [+		\pm	Ш	\mp	\pm	\pm	Н	$\overline{}$	7
Phone No.:						$\overline{}$			90								•				(0	<i>)</i> . Γ										
In what capacity are ye	ou makine	n this cl	laim?											_	Т				_	_				_	\top		$\overline{}$	_	\top			_
iii wilat capacity are yo	Ju making	J IIIIS CI	allii			<u> </u>							$\frac{\perp}{1}$	<u> </u>	<u> </u>		$\frac{1}{1}$	<u> </u>	$\frac{\perp}{\perp}$	<u> </u>		\pm		<u> </u>	\pm	Ш	\pm	$\frac{\perp}{\top}$	\pm	Ш	$\overline{}$	၂
																						_										_
AUTHORISATION I authorize any insurance or knowledge regarding ERGO General Insurance of this authorization upon valid for the duration of the I understand that any permisleading information of I/We hereby understand Company may be utilised and disseminate the same	the insured ce, or its au on request a his claim. erson who le may be subj d, declare, d for proces	d to release thorized and agree knowing ject to person conserses ing the state of t	ease and depression of the contract of the con	y inforr sentati a phot d with ir ution for authorn made	mation ives, for cograp intent to rinsur rise the unde	or the chic of the	quest le pu or fac efrau le fra omp	ted re rpose csimil d or c ud. any the	gard of e le co lecei hat p	ling valu py o ive a bers	this uatir of th any sona by a	s cla ng a nis a insi insi	im a nd d utho uran ealth und	ind t leter oriza ice d	he le rmin ition com	oss ning n is a pan	repo covers va as va by file	orte era alid es a	ed. I ge f as t a cla	und or the he d aim	erstanis classification of the contract of the	and aim nal. aini	this . I kn I agr ng a	info ow l ree t ny n	rma I hav that mate	tion ve a this eriall	will righ autl ly fa	be unt to rizalise,	used rece zatio inco	I by I live a on sh ompl	HDF a cop hall b lete to th	Py be or
Date: DD MM Y	YYY																				SIG	NE	D (C	Clair	— mar	nt or	au	thor	izec	d pe	rsor	า)



Signed (Insured or authorized person)

ACCIDENTAL INJURY - CLAIM FORM

Insured's Stater	nent																														F	orı	m'B
									INS	SUR	RED	INF	-OF	RM/	ATIO	NC																	
Insured's Name:																									I								
Insured's Address:																				T T					<u></u>	T T			<u></u>	Ŧ			
Phone No. (Off):																			Pł	non	e N	o.(F	Res)	: [Ť	Ī	T		T			Ī	
Policy Number:																						`	,										
									CL	A IB	LINI	FOF		ATI	ON											_							
Date of accident:	D D	M M	Y	YY	Y		īmo	e and								۷٠				T					_	_	_		_	T			
								an	J PI	ace	au	Jiue	THE C		1116	u.		_	+	+	+			\pm	+	+	\perp	\Box	\pm	+		\pm	
Please describe in de		TCums	Jance	38 01	acci	ueni		\perp	\perp		\perp	\perp	$^{\perp}$	$^{\perp}$			\Box	\top	+			\Box	\pm	7	 (ati	tack	n se	nar	rate	she	⊥ ∟ if	ner	eded)
Was the assidant rais	atad to the	o Inou	rod'o	20011	notic	n2			⊥_ ∕es			No		If c	- h	now	2			_				_	\ 		T 30	Pai) (II		,aca,
Was the accident rela	ited to the	ilisui	eus	Occu	palic	1111	L				Н	INU	, 	11 8	, i	IOW	: [_		+				+	\pm	_	\perp	\Box	\pm	\pm		\pm	-
Please describe the r	nature of	Incura	d'e in	iuria	c.				\pm	+	+		\pm	\pm	+	+		_	+	\pm	+		\pm	\pm	\pm	\pm	\vdash	\Box	\pm	+	Н	\pm	+
Please list the names				•		nhv	oioi	ono	and	l ho	onit	olo:	_	\pm	+	+		_	_	\pm	+			\pm	\pm	\pm	\vdash	\Box	\pm	\pm	Ш	\pm	+
riease list the fiames	and add	162262	o oi ai	11 11 60	zurig	Pily	SICI	ans	anu	1110	Spit	ais.	+	\pm	$^{+}$	$^{\perp}$		\pm	+	\pm	+		\pm	\pm	÷	\pm	H	П	\pm	\pm	Н	\pm	\pm
		+	\pm	+	++	+			\pm	\pm	H	Н	\pm	\pm	\pm	\pm		$\overline{}$	+	÷	+			\pm	÷	÷	H	一	\pm	+	H	\pm	\pm
Did police or other au	ıthorities	investi	igate	the a	accid	ent?			/es			No)																				
If yes, please provide								er of	f all	inve	esti	gatiı	ng (offic	ers	and	d ag	jeno	cies	: [T	\top	Т	\top		\top	\top		$\overline{}$	
									Т		Т		Ť			Τ				T	T			Ť	Ť	T	T	ī	Ť	T	\Box	Ħ	$\overline{}$
Please list the names	and add	resses	s of a	II trea	ating	/con	sult	ing į	ohy	sicia	ans	or c	othe	er he	ealt	hca	re p	rov	ider	s:				Ť	Ŧ	T	$\overline{\Box}$	$\overline{\Box}$	Ŧ	Ť		\equiv	
								Ŭ.	Ť		T											П		Ť	Ŧ	T	T	П	Ŧ	\mp	\Box	一	
Name:		\equiv	$\overline{\Box}$	\mp	$\overline{\Box}$		T		Ť	Ť	T		Ť	Ť	Ť	Ť		\exists	Ť	Ť	T			Ť	Ť	T	T	a	一	\pm		一	Ŧ
Street Address:			$\overline{\Box}$	\mp	$\overline{\Box}$	+			$\overline{}$	\pm	T	П	$\overline{}$	\mp	T	$\overline{}$		\exists		Ť				\mp	Ŧ	T	T	一	一	\pm	\Box	一	\pm
City:			State	: [$\overline{\Box}$	Ť	T		Ť		F	PinC	ode	e:	Ť	Ť	П	\exists	Ť	Ť	Ť		-	⊃ho	ne:	T	\equiv	П	Ŧ	Ŧ		一	\pm
If hospitalized, please	provide	name	and a	addre	ess o	f ho	spit	al(s)	wh	nere	tre	atm	ent	wa	s re	cei	/ed:	: [Ť	Ť	Ť			T	Τ	T	T	ī	寸	$\overline{}$	$\overline{\Box}$	Ī	〒
																									I								
Do you have any other	er insurar	ice tha	at ma	y pro	vide	COV	era	ge fo	or th	nis a	cci	dent	t or	los	s?			Yes			No)											
If yes, please identify	name, a	ddress	s, and	l poli	cy nu	ımbe	er o	f all	oth	er ir	nsu	ranc	e:												\perp				\perp	\perp			
																									\perp				\perp				
AUTHORISATION I authorize any insuraninformation requested representatives, for the agree that a photograph I understand that any pmisleading information I/We hereby understand Company may be utilise and disseminate the sai	regarding e purpose nic or facsi person who may be su nd, declare ed for proc	this clauding of evaluation imile consumbject to e, consumbject some	laim a luating opy of vingly a prosent a gent a	and the grand of this a and we secution and a call aim relation to the secution of the secutio	ne los d dete author with ir ion for uthor made	ermin rizati ntent r insu rise t und	port ing on i to d uran the er th	ed. I cove s as defra defra de fr Com ne Po	und valid aud aud pan plicy	ders ge fo d as or de l. ny th	tander the the ecei	d thi is cla origi ive a berso ereb	is in aim inal any ona oy a	nforr I. I k I aç insu insu	nati now gree iran alth und	on war I have that ce of	vill bave t this comp	oe u a riç s au pan	ised ght t thor y file	by o re izat es a	HDI ceivion s clai	FC l ve a shal m c	cop l be v onta	GO (y of valid inin	General this difor are are are are are are are are are ar	eral s au the ny m	I Institution	sura rizat ratio eriall	ince, tion i on of ly fal	or it upon this c lse, it	ts a rec clain nco	utho ques n. mple	orized at and ete or
Date: DD M M C	Y Y Y Y	Y														er ac	ccide	ent c	or he	ealth	ins	urar				•						<u>·</u>	rson)
Date: DDMM	YYYY	Y																															



Signature of Patient

HOSPITAL CASH PLAN - CLAIM FORM

Place:

(N.B. To be filled in by the Insured Policy holder, or Insured's authorised representative enjoying power of attorney. Form'C' Issuance of this claim form is not be taken as admission of liability) Name of Policy holder: Name of Employee/Member: (For group insurance policy only) Insured No./Certificate No. (If applicable): Policy Number: Name of Patient: I.D. Card No.: Occupation: Date of Birth: Relationship to the Policy holder: Self Spouse Child Staff/ Member Dependent 1. Have you had any prior treatment for this or related conditions? Yes Yes Doctor's Name: Address: Date: D D 2. Are you making any other insurance claim as a result of this hospitalization/surgery? Yes Yes Name of Insurance Company: Policy Number: 3. (a) Was the hospitalization/surgery a result of an accident? (b) Date of accident: DD MM YYYYY 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: DD MM YYY 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 patients successors and remains valid notwithstanding death or incapacity. A photocopy of this authorisation shall be as valid as the original. I/We hereby understand, declare, consent and authorise the Company that personal health details, medical history and financial information, as provided to the Company may be utilised for processing the claim made under the Policy. I/We hereby also understand, declare and consent that the Company shall have right to retain and disseminate the same to any service provider for providing services related to insurance. Date: D D M M Y Y Y





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

Form'D'

, tatorium g i myon						IN:	SURE	D IN	JFO	RM	ΔΤΙ	ON																	
Insured's Name:								J-11	0																			\top	
Insured's Address:				\Box			++	+	\pm		+	+		\pm	+	+	П		+	+		\Box	\exists	\mp	+	\Box	\mp	\mp	\forall
modrod o 7 tadrodo.								T	Ť		Ť		П	$\overline{}$	$^{+}$	T	П		$^{+}$	Ť	T	П	Ħ	Ť	Ť	П	Ħ	Ť	$\overline{\Box}$
Date of Birth:	D D M M	YY	YY		Mar	ital S	tatus:			Ma	rrie	d			Uni	mar	ried												
Phone No. (Off):								Ы	hon	e No).(R	es):	. [
Name and											Ì																		
address of employer:																								\perp				I	
Policy Number:							In	sure	ed's	Occ	upa	atior	n: [\perp				\perp	
						CL	AIM I	NFC	DRN	/IATI	ON																		
Date of accident:		YYY								Date		first	t tre	atm	ent:	D	D	N	I M		ΥY	/ Y	Y	1					
Please describe in det			sured's i	niur	ies.											H			\perp		T	$\overline{\Box}$	П	, —				\top	_
					100.			$\frac{1}{1}$			\pm		П	$\overline{}$		+			$\overline{}$	\pm	T	П	一	\pm	+	\forall	$\overline{}$	Ŧ	T
Was the accident relat	red to the Insur	ed's occ	runation	?		Yes			lo.	lf s	in I	how	?	$\overline{}$		+			$\overline{}$	\pm	_	П	$\overline{}$	一	+	$\overline{\Box}$	\equiv	十	\pm
VVas tilo doolaciit rolat			Japation			.00		Τ.			,,,,		· .	\pm	+	+			\pm	\pm	_	Н	一	\pm		\exists	\pm	\pm	+
Was the Insured hospi	italized?	Yes	N	0																									
If yes, please list the n		_			als an	nd all	admis	ssio	n/di	ischa	arge	da	tes:																
											Ī					Ī				Ī				Ī	Ī			Ī	Ī
Did the Insured have a	any injury or illn	ess pric	or to the	acc	ident	that	contr	ibut	ed t	o the	e ac	cide	ent d	or to	the	lns	ure	d's	pre	sen	t co	ndif	tion	?		Y	es		No
If yes, please describe):																												
																							\Box				\Box	\perp	
Were any surgical prod	cedures perforr	med?	Ye	S		No																							
If yes, please list all pr	ocedures, and	dates p	erforme	d:																									
																											\Box		
What are the Insured's	s current subjec	ctive syr	nptoms'	?																			Ш				\perp		
What are the objective	findings? (plea	ase incl	ude resu	ults	of cui	rrent	x-ray	s, la	btes	sts, e	etc.)?											\Box	\perp		Ш	\perp	\perp	
																							Ш	\perp			\perp	\perp	
Dates of total disability	: From:	D D	M M	Υ	YY	Υ	То	: D	D	M	М	Υ	′ Y	Υ	Υ														
Dates of partial disabil	ity: From:	D D	M M	Υ	YY	Υ	То	: D	D	M	M	Υ	′ Y	Υ	Υ														
Date Insured able to re	eturn to work:	D D	MM	Υ	YY	Υ																							
Was the Insured seen	by any other p	hysiciar	1?		Yes		No)																					
If yes, please list the n	ames and add	resses o	of all oth	er p	hysic	cians	:																Ш	\perp			\Box	\perp	
																							\Box	\perp			\Box	\perp	
				Α	TTEI	NDIN	IG PH	YSI	CIA	N IN	IFO	RM	ATI	ON															
Name of Attending Phy	ysician:																							T				T	
Insured's Address:																													
																	Pho	ne	No.	: [\Box				I	
I understand that any pe	erson who knowi	ingly and	l with inte	ent to	o defr	raud	or dec	eive	any	/ inst	ıran	ice c	comp	pany	/ file	sad	clair	n co	ntai	ining	g an	ıy m	ate	rially	/ fals	se, ir	ncon	nple	te or
misleading information m	nay be subject to	prosecu	ution for i	nsur	ance	fraud	l.																						
I/We hereby understand	d, declare, cons	ent and	authoris	e the	e Cor	mpan	y that	per	son	al he	alth	ı de	tails	, me	edica	al hi	stor	y ar	nd fi	nan	cial	infc	orma	atior	n, as	pro	vide	ed to	the
Company may be utilised												erst	and,	, dec	clare	and	cor	nsei	nt th	at th	e C	omp	oan	y sha	all ha	ave r	ight	to re	etain
and disseminate the sam	ie to any service	providei	r tor prov	iaing	serv	ices r	elated	I to Ir	nsur	ance	١.																		
Date: DD MMY	-																												
	1 . 1 . 1 . 1																		l		SIG	NEI	D (/	Δττρι	ndin	a Ph	nvsi	ciar	1)



SIGNED(Claimant or authorized person)

ACCIDENTAL INJURY - CLAIM FORM

Accidental Death Form'E' Claimant's Statement Insured's Name: Insured's Address: Marital Status: Date of Birth: Married Unmarried Phone No. (Off): Phone No.(Res): Name and address of last employer: Insured's Occupation(at time of death): Policy Number: Did the Insured have any other accident or life insurance? If yes, please list all companies, policy numbers and insurance amounts: D D M M Y Y Y Date of accident: Time and place accident occurred: Please describe in detail the circumstances of accident: Was the accident related to the Insured's occupation? Yes No 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? Yes No If yes, please provide name and address of Medical Examiner Was a coroner's inquest held? If ves. what was the determination? Claimant's Name: Yrs Relationship to Insured: Age: Claimant's Address: Phone No. (Off): Phone No.(Res): 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. I/We hereby understand, declare, consent and authorise the Company that personal health details, medical history and financial information, as provided to the Company may be utilised for processing the claim made under the Policy. I/We hereby also understand, declare and consent that the Company shall have right to retain and disseminate the same to any service provider for providing services related to insurance. Date: Place:



Consent for Mode of Claim Payment

Name of Insured			
Claim Number Beneficiary Name	Name of Insured		
Beneficiary Name Mode of Payment	Policy Number		
Mode of Payment Cheque Fund Transfer	Claim Number		
(All Flet's are Mandatory in case of Fund Transfer) Insured's Name as per Bank Account Bank Account Number Branch Name Declaration: I Mr./ Mrs/ Ms. Declaration: I Mr./ Mrs/ Ms. Undersigned, legal beneficiary of the above claim, declare that all details mentioned in this form are true and I agree to the mode of payment against the particular claim number mentioned above. Signature of Beneficiary	Beneficiary Name		
Insured's Name as per Bank Account Number Branch Name			
Bank Account Number Branch Name IFSC Code Attachments In Support of Bank Details (Please list, the type of proof submitted) Declaration: I Mr./ Mrs/ Ms. undersigned, legal beneficiary of the above claim, declare that all details mentioned in this form are true and I agree to the mode of payment against the particular claim number mentioned above. Signature of Beneficiary		(All Fields are Mandatory in case of Fund Transfer)	
Branch Name IFSC Code Attachments In Support of Bank Details Cancelled Cheque Bank Passbook Copy Chease tick the type of proof submitted) Declaration: I Mr./ Mrs/ Ms. Undersigned, legal beneficiary of the above claim, declare that all details mentioned in this form are true and I agree to the mode of payment against the particular claim number mentioned above. Signature of Beneficiary Date: D	Insured's Name a Bank Account	as per	
Attachments In Support of Bank Datais In Sup	Bank Account Nu	mber	
Attachments In Support of Bank Details (Please lick the type of proof submitted) Declaration: I Mr./ Mrs/ Ms. undersigned, legal beneficiary of the above claim, declare that all details mentioned in this form are true and I agree to the mode of payment against the particular claim number mentioned above. Signature of Beneficiary Date: D	Branch Name		
In Support of Bank Details (Please tick the type of proof submitted) Declaration: I Mr./ Mrs/ Ms. undersigned, legal beneficiary of the above claim, declare that all details mentioned in this form are true and I agree to the mode of payment against the particular claim number mentioned above. Signature of Beneficiary Date: 0 0 WW YYYYY	IFSC Code	Email address	
undersigned, legal beneficiary of the above claim, declare that all details mentioned in this form are true and I agree to the mode of payment against the particular claim number mentioned above. Signature of Beneficiary	In Support of Bank De		
			Date: DD MM YYYY