HDFC ERGO General Insurance Company Limited

GROUP PERSONAL ACCIDENT CLAIM FORM

HDFC ERGO

Claimant's Statement **Form'A'**

INSURED INFORMATION

Insured's Name:

Insured's Address:

Date of Birth: D D M M Y Y Y Y Marital Status: ☐ Married ☐ Unmarried

Phone No. (Off): Phone No.(Res):

Name and address of employer:

Policy Number: Insured's Occupation:

Does the insured have any other insurance? ☐ Yes ☐ No

If yes, please list all companies, type of insurance, policy numbers and insurance amounts:

CLAIM INFORMATION

Date of accident: D D M M Y Y Y Y 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? ☐ Yes ☐ No 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? ☐ Yes ☐ No

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:

Claimant's Address:

Relationship to Insured: Age: Yrs Phone No. (Off):

Phone No.:

In what capacity are you making this claim?

AUTHORISATION

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: D D M M Y Y Y Y

SIGNED (Claimant or authorized person)

HDFC ERGO General Insurance Company Limited. (Formerly HDFC General Insurance Limited from Sept 14, 2016 and L&T General Insurance Company Limited upto Sept 13, 2016). CIN : U66030MH2007PLC177117. Registered & Corporate Office: 1st Floor, HDFC House, 165 - 166 Backbay Reclamation, H. T. Parekh Marg, Churchgate, Mumbai – 400 020. Customer Service Address: 6th Floor, Leela Business Park, Andheri Kurla Road, Andheri (E), Mumbai – 400 059. For more details on the risk factors, terms and conditions, please read the sales brochure before concluding the sale. Trade Logo of HDFC ERGO General Insurance Company Ltd. displayed above belongs to HDFC LTD and ERGO International AG and used by HDFC ERGO General Insurance Company under license. Toll-free: 1800 2 700 700 | Fax: 91 22 66383699 | care@hdfcergo.com | www.hdfcergo.com. UIN: HDFPAGP03006V010203. IRDAI Reg No. 146.

HDFC ERGO General Insurance Company Limited

ACCIDENTAL INJURY - CLAIM FORM

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: D D M M Y Y Y Y

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? ☐ Yes ☐ No 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? ☐ Yes ☐ No

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: PinCode: 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? ☐ Yes ☐ No

If yes, please identify name, address, and policy number of all other insurance:

AUTHORISATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other person who may have knowledge regarding this claim 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.

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Date: D D M M Y Y Y Y

Signed (Insured or authorized person)

CERTIFICATION OF NO OTHER INSURANCE

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

Date: D D M M Y Y Y Y

Signed (Insured or authorized person)

HDFC ERGO General Insurance Company Limited

HOSPITAL CASH PLAN - CLAIM FORM

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

Form'C'

INSURED INFORMATION

Name of Policy holder: ____

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

Policy Number: ____ Insured No./Certificate No. (If applicable): ____

Name of Patient: ____

Occupation: ____ I.D. Card No.: ____ Date of Birth: DD MM YYYY

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: DD MM YYYY

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? ☐ Yes ☐ Yes

   (b) Date of accident: DD MM YYYY 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: DD MM YYYY Date of Discharge: DD MM YYYY

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: DD MM YYYY

Place: ____

Signature of Patient

HDFC ERGO General Insurance Company Limited

ACCIDENTAL INJURY - CLAIM FORM

HDFC ERGO

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

Form'D'

INSURED INFORMATION

Insured's Name:

Insured's Address:

Date of Birth: D D M M Y Y Y Y Marital Status: ☐ Married ☐ Unmarried

Phone No. (Off): Phone No.(Res):

Name and address of employer:

Policy Number: Insured's Occupation:

CLAIM INFORMATION

Date of accident: D D M M Y Y Y Y Date of first treatment: D D M M Y Y Y Y

Please describe in detail the nature of the Insured's injuries:

Was the accident related to the Insured's occupation? ☐ Yes ☐ No If so, how?

Was the Insured hospitalized? ☐ Yes ☐ No

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? ☐ Yes ☐ No

If yes, please describe:

Were any surgical procedures performed? ☐ Yes ☐ No

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, labtests, etc.)?

Dates of total disability: From: D D M M Y Y Y Y To: D D M M Y Y Y Y

Dates of partial disability: From: D D M M Y Y Y Y To: D D M M Y Y Y Y

Date Insured able to return to work: D D M M Y Y Y Y

Was the Insured seen by any other physician? ☐ Yes ☐ No

If yes, please list the names and addresses of all other physicians:

ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician:

Insured's Address:

Phone No.:

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Date: D D M M Y Y Y Y

SIGNED (Attending Physician)

HDFC ERGO General Insurance Company Limited

ACCIDENTAL INJURY - CLAIM FORM

Accidental Death
Claimant's Statement

Form'E'

INSURED INFORMATION

Insured's Name:

Insured's Address:

Date of Birth: D D M M Y Y Y Y

Marital Status: ☐ Married ☐ Unmarried

Phone No. (Off):

Phone No.(Res):

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? ☐ Yes ☐ No

If yes, please list all companies, policy numbers and insurance amounts:

CLAIM INFORMATION

Date of accident: D D M M Y Y Y Y

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? ☐ Yes ☐ No 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? ☐ Yes ☐ No

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? ☐ Yes ☐ No If yes, what was the determination?

CLAIMANT INFORMATION

Claimant's Name:

Age: Yrs

Relationship to Insured:

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.

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Date: D D M M Y Y Y Y

Place:

SIGNED(Claimant or authorized person)

HDFC ERGO General Insurance Company Limited

Consent for Mode of Claim Payment

Name of Insured ______________________

Policy Number ______________________

Claim Number ______________________

Beneficiary Name ______________________

Mode of Payment Cheque ☐ Fund Transfer ☐
(Please tick for mode of payment)

(All Fields are Mandatory in case of Fund Transfer)

Insured's Name as per Bank Account ______________________

Bank Account Number ______________________

Branch Name ______________________

IFSC Code ______________________ Email address ______________________

Attachments
In Support of Bank Details
(Please tick the type of proof submitted)
Cancelled Cheque ☐ Bank Passbook Copy ☐

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
Stamp Required in case of Company

Date: D D M M Y Y Y Y