



INDIVIDUAL PERSONAL ACCIDENT - CLAIM FORM

Claimant's Statement

INSURED INFORMATION

Insured's Name:

Insured's Address:

Mobile No.: Alternate No.:

Email Id: Policy Number:

Policy Period Insured Profession:

Name and address of employer:

ACCIDENTAL DEATH & PERMANENT DISABILITY

Date of accident: Place accident occurred:

Particulars of the accident /Description of accidental details

Was the accident related to the Insured's occupation? Yes No

Whether reported to Policy station Yes No If Yes Police station Name

In case hospitalised list the names and addresses of all treating physicians and hospitals

Please indicate whether claim is in respect of (tick boxes) Accidental Death Permanent Total Disability

For Accidental Death Date of accident: Place of Death:

For child education Benefit: Provide details of dependent child (If applicable)

Date of Birth Child 1 Date of Birth Child 2

For Permanent Total Disability

Details of permanent disablement:

ACCIDENTAL HOSPITALIZATION / HOSITAL CASH

Date of accident: Time accident occurred: AM/PM Place accident occurred:

Date of admission: Date of Discharge:

Particulars of the accident /Description of accidental details

Please describe the nature of Insured's injuries:

Name and address of all treating physicians and hospital

City: State: PinCode: Phone:

Whether reported to Policy station Yes No If Yes Police station Name

TEMPORARY TOTAL DISABLEMENT /BROKEN BONES /ACCIDENTAL INJURY

Date of accident: Time accident occurred: AM/PM Place accident occurred:

Date of admission: Date of Discharge:

Particulars of the accident /Description of accidental details

Whether reported to Policy station Yes No If Yes Police station Name

Details of Temporary disablement

Dates of Temporary disablement: From: To:

Name and address of all treating physicians and hospital

City: State: PinCode: Phone:

Date Insured able to return to work:

CLAIMANT INFORMATION - INSURED OR NOMINEE (NOMINEE ONLY IF INSURED IS EXPIRED)

Claimant's Name
Relationship to Insured Claimant's Address

City State Pin Code
Mobile Alternate no

Date:
Place:

Signature of the claimant

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 _____ Date:
Stamp Required in case of Company



Individual Personal Accident - Claim Document Checklist

(Additional documents if required will be requested by the insurer)

***Photocopy of Aadhaar Card /Aadhaar Card number is mandatory for all claims**

Personal Accident - Death

- Duly filled and signed Claim Form
- FIR from Police station/ Medico legal certificate from hospital (MLC Copy)
- Post Mortem Report, Inquest Panchnama
- Cause of death Certificate from treating doctor
- Death Certificate from Municipal Corporation
- Histopathology or Chemical viscera or blood analysis report from the hospital (If done)
- KYC form and KYC documents (ID and address proof e.g Pan card/Aadhaar card/Ration card/Passport etc.)
- Original cancelled cheque with name of Nominee printed on cheque is required. If name is not printed on cheque please attach first page of bank passbook / Bank statement with stamp

Personal Accident - Permanent Disability

- Duly filled and signed Claim Form
- FIR from Police station/ Medico legal certificate from hospital (MLC Copy)
- Disability Certificate from Government Hospital
- All treatment papers and Investigation report from hospital
- Photograph with disable part
- KYC form and KYC documents (ID and address proof e.g Pan card, Aadhaar card, Ration card, Passport etc.)
- Original cancelled cheque with Payee name (Insured) name printed on cheque is required. If name is not printed on cheque please attach first page of bank passbook/Bank statement with bank stamp

Accidental Hospitalization Benefit /Hospital cash benefit

- Duly filled and signed claim form
- FIR from Police station/ Medico legal 3.certificate from hospital (MLC Copy)
- Copy of discharge summary of hospitalization, if any
- KYC form and KYC documents (ID and address proof e.g Pan card, Aadhaar card, Ration card, Passport etc.)
- Original Hospital Final Bill with payment receipt, Original Medicine Bills, Prescriptions. Original Investigation reports and bills
- Original cancelled cheque with Payee name (Insured / Nominee) name printed on cheque is required. If name is not printed on cheque please attach first page of bank passbook /Bank statement with bank stamp

Temporary total disablement /Broken bones /Accidental injury

- Duly signed filled claim form
- Discharge card / summary from hospital
- Investigation report like X-RAY / MRI / CT scan etc if any
- Fitness certificate from treating doctor
- Leave certificate from employer (If or are salaried) or ITR of last 2 yrs if business men
- KYC form and KYC documents (ID and address proof e.g Pan card, Aadhaar card, Ration card, Passport etc.)
- Original cancelled cheque with Payee name (Insured) name printed on cheque is required. If name is not printed on cheque please attach first page of bank passbook / Bank statement with stamp