HDFC ERGO General Insurance Company Limited

Claim Form

my:health Group Personal Accident Insurance

Important:

- Please fill the form in BLOCK LETTERS. Please answer all questions fully and correctly. All details with * are mandatory.
- Kindly contact the Company's Office or agent for any doubt or clarification on the claim form.
- Issuance of this form is not an admission of liability or a waiver of the terms, conditions and exceptions of the insurance contract.

Policy No.---------- Certificate No. ---------- Claim No. ----------
Name of the Insured (Group Name/Corporate Name) ----------

1. PERSONAL DETAILS

NAME (In block letters)*:a) Insured----------
b) Claimant----------
c) Relationship (if Insured and claimant are different)
Address: ----------
City----------State----------
PIN----------
Occupation: ----------
Age: ----------

2. DETAILS OF ACCIDENT

Date (DD/MM/YYYY)*: ----------
Time*: ----------
Place and Location (Full Address)*: ----------

Cause description of accident*: ----------

3. DETAILS OF INJURIES

Specify Injured Parts of Body. If injury sustained in eye or limb, please specify left or right ---------- ----------
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4. WITNESSES

NAME (In block letters):----------
Address: ----------
City: ---------- State ----------
PIN: ----------

5. TREATMENT DETAILS

- Attending/treating Doctor
  Name: ----------
  Address: ----------
  Phone: ----------

- Family Doctor
  Name: ----------
  Address: ----------
  Phone: ----------

HDFC ERGO General Insurance Company Limited

Claim Form

- Hospital(s)
  Name: ----------
  Address: ----------
  Phone: ----------

6. CONTACT DETAILS – where and when can our representative may visit you, if necessary.*

Address where Available ----------
Phone No. ----------

7. Please indicate the appropriate section under which you are claiming along with the amount*

Coverage	**Amount (Rs.)**
Total Temporary Disablement	
Permanent Total Disablement	
Permanent Partial Disablement	
Accidental Death	
Add on covers	

8. Period of disability - applicable for claim under Temporary total disability*

(The period should be the actual days when fully confined to bed on Medical Advice)
From: (dd/mm/yyyy) To: dd/mm/yyyy)

9. Past Insurance History*

- Have you made any claims in the past ? YES/NO
- If YES, please give details including accident and Insurance details

Name of Ins co	Policy no.	Capital Sum Insured	Nature of claim	Status of the claim

10. **Are you currently insured under any other Policy?*** YES/NO

If YES, please give full details

Name of Insurance co.	Policy no.	Capital Sum Insured	Details of claim lodged	Status of the claim

11. **Have the Police Authorities been informed of this accident?.** If yes, please specify the name of the Police station and the FIR _____

I/We hereby declare that the foregoing statements made by me/us are true in all respects, that I/We have not attempted to conceal from the Company anything with which it ought to be made acquainted and that if I/We have made or in any further declaration the Company may require shall make any false or fraudulent statement or untrue averment whatever, the policy shall be void and my/our right to compensation forfeited. I /We are willing if required, to make and provide to the company a statutory declaration of the whole of the foregoing statement or of any other statement made in connection with this claim

Date:
Place:

Signature of the Insured/Insured Person

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Claim Form

ATTENDING PHYSICIAN'S STATEMENT

PLEASE ANSWER ALL QUESTIONS

1. Name Of the Injured Person: _____
   Age: _____
2. Nature of the Accident and Details of Injuries sustained. Please specify the parts of the body. If injury sustained in eye or limb, specify left or right._____
3. Does the Cause of Accident as stated by the Claimant tally with the Injuries noticed by you? _____
4. Are the Injuries solely due to the accident or traceable to any previous injuries/ disease/ infirmities? _____
5. Was the Injured Person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition. _____
6. Was Injured Person under the influence of intoxicants or drugs at the time of accident ? _____
7. Was the Injured Person hospitalized? If so for what period?
   From ---------- (dd/mm/yyyy) To ---------- (dd/mm/yyyy)
8. Details of treatment and Operations (if any) performed: _____
9. Give all dates of treatment:
   Home: From ---------- (dd/mm/yyyy) To ---------- (dd/mm/yyyy)
   Clinic/ Hospital: From ---------- (dd/mm/yyyy) To ---------- (dd/mm/yyyy)
10. Please fill one of the following to indicate the nature of the disability.

Nature of disability as per the attending doctor	Please specify against the appropriate nature of disability
Temporary Total Disablement	
Permanent Total Disablement	
Permanent Partial Disablement	

11. In case of Temporary Total disability how long was or will the claimant be totally disabled from current occupation?
    From ----------(dd/mm/yyyy) To ----------(dd/mm/yyyy)

Doctors Name: _____

Doctor's Signature

Regn No. _____

Date:

Address :_____