MAGMA
General Insurance Limited

CLAIM FORM - SARAL SURAKSHA BIMA, MAGMA GIL

UIN: MAGPAIP21642V012021

Claim No._____

All questions must be answered fully. If there is insufficient space, kindly use a separate sheet which can be attached to this form. If any section is not fully completed or left blank, the form will be returned for completion.

The issue or acceptance of this form is not to be construed as an admission of liability by Magma General Insurance Limited.

A. The Insured

Name

Address

City State Pin Code

Tel No. Office Mobile

E-mail

B. Policy Details

Policy No. Period of Insurance to

C. Claimant/Deceased Details

Name

Sex ☐ Male ☐ Female Date of Birth _____/_____/_____

Occupation_____ Relationship with Insured_____

Address where a representative on behalf of Magma General Insurance Limited can visit _____

_____

D. Accident Details

Date of accident (dd/mm/yy) _____/_____/_____ Time of accident _____ am/pm Did it occur at work ☐ Yes ☐ No

Where did the accident occur _____

How did the accident happen _____

_____

Was the accident reported to Police ☐ Yes ☐ No

If not, kindly state the reasons _____

_____

Are there any witnesses to the accident ☐ Yes ☐ No

If yes, kindly provide name(s) and contact details _____

_____

Was Post-mortem conducted ☐ Yes ☐ No If yes, kindly attach a copy of the Report

Describe the nature of injuries received _____

_____

Period of disability

Total disability-confined to Bed (dd/mm/yy)_____/_____/_____ to_____/_____/_____

Partial disability – confined to House (dd/mm/yy)_____/_____/_____ to_____/_____/_____

If partially disabled, kindly state the daily duties of usual occupation which cannot be performed _____

_____

E. Hospitalization / Treatment Details

Name & contact details of doctor first consulted after the accident

City State Pin Code

Tel No. Office Landline Mobile

E-mail

Name and contact details of other doctors consulted

City State Pin Code

Tel No. Office Landline Mobile

E-mail

Name and contact details of claimant's usual medical practitioner

City State Pin Code

Tel No. Office Landline Mobile

E-mail

Whether hospitalized following the accident ☐ Yes ☐ No

If yes, name & address of hospital

City State Pin Code

Tel No. Office E-mail

Period of hospitalization (dd/mm/yy)_____/_____/_____ to_____/_____/_____

F. Details of Dependent Children (For claim under Education Grant Benefit)

Name of Dependent Child	Age of Dependent Child	Education Pursuing	Name of School/ College/Institute

Documents required:

1) Admission card
2) ID card
3) Last year's Mark sheet
4) Letter from school, college, institute affirming he/she is studying in their organization.

G. Other Insurances

Details of any other insurance (arranged by self, spouse, parents or employer) under which claimant/deceased is covered

Name of Insurer	Policy Number	Period of Insurance	Coverage	Sum Insured

H. Claim Amount

I hereby warrant the truth of foregoing statement and sincerely declare that I have not suppressed or concealed any information that is material to this claim. I understand that false declarations may result in Magma General Insurance Limited being able to refuse to pay a claim.

I authorize any hospital, physician or any other medical provider who has attended me or examined me to furnish Magma General Insurance Limited such details of my medical history/treatment as they may require.

_____

Signature of Insured/claimant

Date _____

Documents to be attached to the claim form:

Medical Attendant's Certificate

Name of patient

Occupation_____ How long have you known this patient _____

Are you his/her usual Medical Attendant ☐ Yes ☐ No

Kindly state the nature of and extent of injuries _____

_____

Is the injury consistent with patient's description of the accident ☐ Yes ☐ No

Are the injuries connected with any previous accident, infirmity or disease ☐ Yes ☐ No

If yes, please provide details _____

_____

Will the recovery be retarded due to above ☐ Yes ☐ No

If yes, kindly provide details _____

When were you first consulted for this injury/disability (dd/mm/yy)_____/_____/_____

Please give details of other consultations –

Doctor's name

Address

City State Pin Code

Tel No. Office Landline Mobile

E-mail

Are you still treating the patient for the injury/disability ☐ Yes ☐ No

Kindly provide details of treatment prescribed _____

_____

If X-ray has been done, kindly state the findings and Radiologist's report _____

_____

If hospitalized, name of hospital _____

Period of hospitalization (dd/mm/yy)_____/_____/_____ to_____/_____/_____

Date & Nature of surgical procedure, if any (dd/mm/yy)_____/_____/_____. _____

Are there any complications which may retard the recovery : _____

_____

Has the patient suffered from similar injury/disability previously? ☐ Yes ☐ No

If yes, when, nature and duration of the _____

_____

Was the patient under the influence of intoxicants or drugs at the time of accident ☐ Yes ☐ No

While under your care and direction, how long was or will the patient be:

a) Totally unable to perform each and every duty of his/her usual occupation

From (dd/mm/yy)_____/_____/_____ to_____/_____/_____

b) Partially disabled from performing his/her usual occupation

(dd/mm/yy)_____/_____/_____ to_____/_____/_____.

Nature of disablement (in case of permanent disability)

Permanent _____ Total Disability _____

Permanent _____ Partial disability _____

Prognosis Please comment on any additional factor that may prolong recovery from injury/disability _____

_____

_____

I certify that I have personally attended to the named above patient and the above statements are correct.

_____ _____ _____

Signature* Qualification Reg.No.

Name

Address

City State Pin Code

Tel No. Office Mobile

E-mail

Date _____

*Kindly Affix official seal/stamp