GROUP ACCIDENT SURAKSHA POLICY CLAIM FORM

ISSUE OF THIS CLAIM FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

If any detail or information is not readily available please do not delay the dispatch of this form and other particulars may be sent later

Claim Number: _____

Policy Number: _____

Period of Insurance: _____ To _____

1. DETAILS OF THE INSURED/ CLAIMANT

Name of the Claimant:

Relation with the insured:

Name of the Insured:

Address:

City: State: Pin No:

Contact Number: Email Id:

2. ACCIDENT DETAILS

1. Date & time of Accident/occurrence:
2. Place of Accident/Occurrence:
3. Description of the Accident/Occurrence:
4. Witness name, address and contact number:
5. Was the injured person under the influence of alcohol/drugs at the time of accident YES ☐ or NO ☐
6. Driving license details, in case of self-accident:

3. DETAILS OF INJURY/DEATH:

1. Details of injuries sustained with name of the parts:
2. If disabled, specify the nature of disability:
3. Specify the disability percentage in case of Permanent Partial Disablement:
4. In case of death, Cause of death:
5. Nominee details (for death cases only) Name, relation with the insured and address:

4. TREATMENT DETAILS

Casualty Doctor

Name:

Address:

Nontact Number:

Family Doctor

Name:

Address:

Nontact Number:

Hospital Details

Name:

Address:

Nontact Number:

5. CONFINEMENT DETAILS

Full Confinement period
(Actual days when fully confined to bed on Medical Advice)

From _____ To _____ Total days _____

Partial Confinement Period

From _____ To _____ Total days _____

6. MEDICAL EXPENSES – SUBJECT TO COVERAGE UNDER THE POLICY

Date	Receipt Number	Particulars	Amount

Please attach separate sheet in the above format for additional bills

7. CLAIMS HISTORY

Have you made any claims in the past? Yes ☐ or No ☐

If Yes, Please give the details of cause of accident/occurrence, nature of injury, policy details and claim amount.

8. OTHER INSURANCE

Are you insured under any other policy Yes ☐ or No ☐

If Yes, Please give full particulars of Name of the insurance company, Policy number, period of insurance and claim details.

9. CLAIM UNDER OTHER HEADING (SUBJECT TO POLICY COVERAGE AND LIMITS)

CLAIM UNDER WHICH COVERAGE	CLAIMED AMOUNT

LIST OF DOCUMENTS REQUIRED FOR CLAIM SETTLEMENT

1. Claim Form
2. Police FIR / Panchnama
3. Medical Certificate
4. Investigation/Lab Test Report
5. Discharge Certificate
6. Leave Certificate
7. Disability Certificate
8. Death Certificate – for Death cases only.
9. Post Mortem Report – for Death cases only.

DECLARATION

I/We agree to provide additional information to the company, if required. I/We the above mentioned, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and if I/We have made, or in any future declaration the Company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, the policy shall be void and all rights to recover there under in respect of past or future accident shall be forfeited.

Place: _____

Date: _____

Signature of the insured /Nominee

ATTENDING PHYSICIAN'S STATEMENT

1. Name of the Insured:
2. Age of the insured:
3. Address:
4. Type of accident:
5. Nature of injuries sustained:
6. Does the Cause of accident as stated by the Claimant tally with the Injuries noticed by you ☐ Yes OR ☐ No
7. Was the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition? ☐ Yes OR ☐ No
8. Was the Claimant hospitalised, if yes period From: _____ To: _____
9. Was the treatment /Operations carried by you ☐ Yes OR ☐ No
10 Give details of the treatment Hospital: From: _____ To: _____
Home: From: _____ To: _____
11. Was he/she was under the influence of intoxicants or drugs at the time of accident ☐ Yes OR ☐ No
If Yes, please provide the details:
12. Are you his/her family doctor ☐ Yes OR ☐ No
If yes, have you treated him/her for any previous illness or injury, please provide the details:
13. Is there any Doctors also associated in the treatment, please provide the details:
14. Has the accident been reported to the Police Authorities, if yes please provide the details:
15. Is the claimant Totally Disable from each and every occupation:
16. How long the claimant will be totally disabled from current occupation: From: _____ To: _____
How long the claimant will be partially Disabled from the current location: From: _____ To: _____
Estimated date of return to work:
17. What is the Prognosis:

Signature of the Doctor: _____

Name of the Doctor: _____ Registration Number: _____

Address: _____

Contact number: _____

Date: _____