

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.

Claim Number \_\_\_\_\_

**A. THE INSURED:**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Pin: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_  
 Email ID: \_\_\_\_\_

**B. POLICY DETAILS:**

Policy Number \_\_\_\_\_ Period of Insurance : From **DDMMYYYY** To **DDMMYYYY**

**C. CLAIMANT/DECEASED DETAILS:**

Name: \_\_\_\_\_  
 Sex:  Male  Female Date of Birth: **DDMMYYYY**

Occupation \_\_\_\_\_ Relationship with Insured \_\_\_\_\_

Address where a representative on behalf of **Magma General Insurance Limited** can visit \_\_\_\_\_

**D. ACCIDENT DETAILS:**

Date of accident <b>DDMMYYYY</b>	Time of accident <b>HH:MM</b> : <input type="checkbox"/> am <input type="checkbox"/> pm <input type="checkbox"/>
Did it occur at work?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Where did the accident occur?	
How did the accident happen?	
Was the accident reported to Police? If not, kindly state the reasons	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are there any witnesses to the accident? If yes, kindly provide name(s) and contact details	Yes <input type="checkbox"/> No <input type="checkbox"/>
Was Post-mortem conducted? If yes, kindly attach a copy of the Report	Yes <input type="checkbox"/> No <input type="checkbox"/>
Describe the nature of injuries received.	
Period of disability Total disability-confined to Bed Partial disability – confined to House	From <b>DDMMYYYY</b> To <b>DDMMYYYY</b> From <b>DDMMYYYY</b> To <b>DDMMYYYY</b>
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		
Name and contact details of other doctors consulted		
Name and contact details of claimant's usual medical practitioner		
Whether hospitalized following the accident If yes, name & address of hospital	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Period of hospitalization	From <input type="text"/> DDMMYYYY	To <input type="text"/> DDMMYYYY

**F. 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

**G. 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.

 Date  DDMMYYYY

Signature of Insured/claimant

## Documents to be attached to the claim form:

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## Medical Attendant's Certificate

Name of patient		
Occupation		
How long have you known this patient?		
Are you his/her usual Medical Attendant? Kindly state the nature of and extent of injuries	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the injury consistent with patient's description of the accident?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are the injuries connected with any previous accident, infirmity or disease? If yes, please provide details	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Will the recovery be retarded due to above? If yes, kindly provide details	Yes <input type="checkbox"/>	No <input type="checkbox"/>
When were you first consulted for this injury/disability?	[D] [D] [M] [M] [Y] [Y] [Y] [Y]	
Please give details of other consultations – Doctor's name Address		
Are you still treating the patient for the injury/disability? Kindly provide details of treatment prescribed	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If X-ray has been done, kindly state the findings and Radiologist's report		
If hospitalized, name of hospital		
Period of hospitalization	From [D] [D] [M] [M] [Y] [Y] [Y] [Y] To [D] [D] [M] [M] [Y] [Y] [Y] [Y]	
Date & Nature of surgical procedure, if any	[D] [D] [M] [M] [Y] [Y] [Y] [Y]	
Are there any complications which may retard the recovery:		
Has the patient suffered from similar injury/disability previously? If yes, when, nature and duration of the treatment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Was the patient under the influence of intoxicants or drugs at the time of accident?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 b) Partially disabled from performing his/her usual occupation	From [D] [D] [M] [M] [Y] [Y] [Y] [Y] To [D] [D] [M] [M] [Y] [Y] [Y] [Y] From [D] [D] [M] [M] [Y] [Y] [Y] [Y] To [D] [D] [M] [M] [Y] [Y] [Y] [Y]	
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.

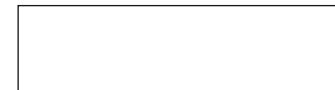
Signature\* \_\_\_\_\_ Qualification \_\_\_\_\_ Reg. No. \_\_\_\_\_

Name: \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Date 

D	D	M	M	Y	Y	Y	Y
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\*Kindly Affix official seal/stamp