CLAIM FORM – LOAN GUARD

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

a) Claim form is to be filled in capital letter & signed by the insured/claimant.

b) Please do not leave any column unanswered.

c) Please read carefully the attached list of documents required to speed up processing of your claim.

d) If there is insufficient space, kindly use a separate sheet which can be attached to this form.

Claim Number:

DETAILS OF INSURED

Name of the Insured
First Name Middle Name Last Name

Name of the Claimant
First Name Middle Name Last Name

Relationship with Insured Designation (If applicable)

Date of Birth D D M M Y Y Y Y Sex: Male Female

Email ID

Communication Address

City/Taluka District

State Pin Code STD code

Phone No Mobile

DETAILS OF INSURED

Policy No / / /

Period of insurance from to Sum Insured

DETAILS OF OTHER POLICY

Have you been insured under any Policy of any other insurance companies? Yes No

If yes please enclose photocopies of all previous policies.

Date of commencement of very first insurance for the from to

Beneficiary with continuous insurance coverage

BENEFITS

Section 1 – Critical Illness: (Various Plans*)

*please refer policy documents and schedule for details.

1 star Plan		2 Star Plan		3 Star Plan		4 Star Plan	

Section II - Personal Accident

A.	Death Due to an Accident:		B.	Permanent Total Disability due to an Accident:	

DETAILS OF INCIDENCE

Nature of Disease / Illness / Injury	
Cause of Disease / Illness / Injury	
Date of incidence	D D M M Y Y Y Y Time of incidence : AM/PM
Place of incidence	
Incidence Reported to	
Are there any witness to incidence	Yes No
Names and Address of witnesses	

MAGMA General Insurance Limited

LOAN GUARD - CLAIM FORM

DETAILS OF HOSPITAL APPLICABLE FOR SECTION I & II

Was the insured person moved to hospital immediately after the incidence ☐ Yes ☐ No

If yes, please fill in the following

Date of admission ☐☐☐☐☐☐☐☐ Time of admission ☐☐ : ☐☐ AM/PM.

Date of discharge ☐☐☐☐☐☐☐☐ Time of discharge ☐☐ : ☐☐ AM/PM.

Name of the Hospital

Address

City/Taluka District

State Pin Code STD code

Phone No Mobile

Particulars of treatment

MEDICAL PRACTITIONER'S DECLARTION APPLICABLE FOR SECTION I & II

I hereby certify that ____ was treated by me on ____ for ____ which first incurred on ____

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Details

Name of the treating

First Name Middle Name Last Name

Medical Practitioner

Registration No Qualification

Date:

Place:

Stamp and Signature of the Medical practitioner

Section III – Loss of Job ☐

Loan Details:

Loan A/c No: -

Name & Address of Bank / Institution

Contact Details (Phone / E-Mail)

Type of loan taken Date of inception of repayment

Amount of loan taken Loan Balance as on date

Last Month for repayment EMI / Pre EMI Rs.

Employer Details:

Name of Organization employed

Address

contact numbers of the Company in which employed

Designation

Date of appointment Date of confirmation:

Nature of employment ☐ Permanent ☐ probation ☐ casual ☐ temporary ☐ seasonal ☐ contractual

Date of termination ☐ suspension ☐ retrenchment

Last working day ☐☐☐☐☐☐☐☐ Last salary after termination / suspension Rs. ☐☐☐☐☐☐☐☐☐☐☐

Period of suspension if applicable ☐☐☐☐☐☐☐☐☐☐ Amount drawn during suspension period Rs. ☐☐☐☐☐☐☐☐

Date of re-employment and details: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Any other relevant details : (Please attach separate sheet if necessary)

Please attach the following documents with the completed claim form

1. Certificate if applicable from the Bank stating the amortization schedule, the EMI Amounts, Principal Outstanding, etc.
2. Certificate from the employer of the Insured person confirming the termination, dismissal, temporary suspension or retrenchment from employment of the Insured person furnishing the date of termination, dismissal, temporary suspension or retrenchment from employment of the Insured person with the reasons for the same. In case of temporary suspension the period of suspension should also be mentioned in such certificate
3. Appointment and confirmation letter of employment.

Section IV – Fire and Allied Perils – Dwelling and Household Contents ☐
(Please refer to Annexure A)

Section V- Business Interruption(Applicable for Commercial Establishments)
(Please refer to Annexure B)

DETAILS OF CLAIMED AMOUNT

	Description	Amount (Rs.)
(A)	Critical Illness	
(B) i	Death	
(B) ii	Permanent Total Disability	
(C)	Loss of Job	
(D)	Fire and Allied Perils – Dwelling and Household Contents	
(E)	Business Interruption	
TOTAL AMOUNT CLAIMED		

ENCLOSURES

☐ Claim form duly signed
☐ Policy copy
☐ Claim intimation
☐ FIR/ MLC copy
☐ Death certificate
☐ Post mortem report
☐ Inquest / Coroner's report
☐ Final police report
☐ Disability Certificate
☐ Investigation reports
☐ Medical certificate
☐ Nominee certificate
☐ Employer Certificate
☐ Photograph of the injured with reflecting disablement
☐ Any other documents

If yes please specify: _____

Any other information You wish to state: _____

INSURED'S /CLAIMANT'S DECLARATION

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 declaration/s may result in Magma General Insurance Limited being able to refuse to pay the claim.

The receipt of this claim form/ other supporting / related document does not constitute or be deemed to constitute an agreement by the Magma General Insurance Limited of the claim and Magma General Insurance Limited reserves the right to process or reject or require further / additional information in respect of the claim.

Date: D D M M Y Y Y Y

Place: ☐☐☐☐☐☐☐☐☐☐☐☐

Signature of Claimant: _____

Name of the Claimant: _____

MAGMA
General Insurance Limited

LOAN GUARD - CLAIM FORM

TO BE COMPLETED BY NOMINEE IN THE EVENT OF INSURED'S DEATH

Name of the Nominee: First Name Middle Name Last Name

Relationship with Claimant:

Date of Birth: D D M M Y Y Y Y Sex: ☐ Male ☐ Female Email ID:

Communication:

Address:

City/Taluka: District: State:

Pin Code: STD code: Phone No.:

Mobile:

*If nominee is minor, kindly provide the Legal Guardian details

First Name Middle Name Last Name

Name of the Guardian:

Address:

City/Taluka: District: State:

Pin Code: STD code: Phone No.:

Mobile:

Date of Birth: D D M M Y Y Y Y Sex: ☐ Male ☐ Female

I/We hereby declare and warrant the truth of the foregoing particulars in every respect. I /We agree that if I/We have made orshall make false or untrue statement, suppression or concealment, my/our right to compensation shall be forfeited. I/We also hereby declare that I am/we are accepting the amount in full discharge of your obligations under the policy to the Insured Person and /or his/her legal heirs. I/we will hold you indemnified in the event of any claim under this policy being made against you by any other person or persons.

Date: D D M M Y Y Y Y

Place:

Signature of Nominee: _____

Name of the Nominee: _____