



MAGMA
General Insurance Limited

OFFICE PACKAGE INSURANCE POLICY (RETAIL)

Claim Form

Section 8: Personal Accident Insurance

Magma General Insurance Limited (erstwhile Magma HDI General Insurance Company Limited) | www.magmainurance.com
| E-mail: customercare@magmainurance.com | Toll Free: 1800 266 3202 | Registered Office: Equinox Business Park, Tower 3, Ambedkar Nagar, 2nd Floor, Unit Number 1B & 2B, LBS Marg, Kurla (West), Mumbai - 400070, Maharashtra, India. | CIN: U66000MH2009PLC460693 | IRDAI Reg. No. 149 | Office Package Insurance Policy (Retail) | Product UIN: IRDAN149RP0001V02201415 | For complete list of details on exclusions, risk factors, terms & conditions, please read the policy documents carefully before concluding a sale. | Trade Logo displayed above belongs to Magma Ventures Private Limited and is used by Magma General Insurance Limited under license. | Chat with MIRA on our website or say "Hi" on WhatsApp No. 7208976789 (CF.OPP.ver04.12.25)

Office Package Insurance Policy (Retail)

Section 8: Personal Accident Insurance Claim Form

Claim No. _____

Policy 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.

A. The Insured

Name _____

Address _____

Tel No. Office _____ Mobile _____ email _____

B. Policy Details

Policy No. _____ Period of Insurance _____ to _____

C. Claimant/Deceased Details

Name _____

Sex Male ☐ Female ☐

Date of Birth ____/____/____

Occupation _____

Relationship with Insured _____

Employee/Member identification number (for group policies) _____

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



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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

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. Hospitalisation/treatment Details

Name & contact details of doctor first consulted after the
accident _____



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Name and contact details of other doctors
consulted _____

Name and contact details of claimant's usual medical practitioner

Whether hospitalized following the accident Yes ☐ No ☐
If yes, name & address of hospital

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

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 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 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 _____



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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 – Dr's name,
address _____

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 ☐



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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

Date

*Kindly Affix official seal/stamp

