

# HOUSEHOLDER'S PACKAGE POLICY (RETAIL)

## Group Personal Accident Insurance Claim Form



## Householder's Package Policy (Retail)

### Claim Form Group Personal Accident Insurance

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*

#### A. The Insured

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

Address : \_\_\_\_\_  
\_\_\_\_\_

Tel No. : Office : \_\_\_\_\_ Mobile : \_\_\_\_\_

Email : \_\_\_\_\_

#### B. Policy Details

Policy No.: \_\_\_\_\_

Period of Insurance : \_\_\_\_\_ to \_\_\_\_\_

#### C. Claimant

(a) Name : \_\_\_\_\_

Address : \_\_\_\_\_  
\_\_\_\_\_

Tel No. : Office : \_\_\_\_\_ Mobile : \_\_\_\_\_  
Email : \_\_\_\_\_

Relationship with insured person : \_\_\_\_\_

(b) Insured person's details

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

Sex : **Male** ☐ **Female** ☐

Date of Birth : \_\_\_\_/\_\_\_\_/\_\_\_\_



Occupation : \_\_\_\_\_

Employee/Member identification number (for group policies) : \_\_\_\_\_

Address where a Medical Practitioner on behalf of *Magma General Insurance* 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 Yes—Name of the police station where FIR was lodged and FIR No and date : \_\_\_\_\_  
\_\_\_\_\_

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 : \_\_\_\_\_  
\_\_\_\_\_

In case of death of insured person, kindly provide following information :

Date and time of death : \_\_\_\_\_ hrs on \_\_\_\_/\_\_\_\_/\_\_\_\_

Whether post-mortem was conducted : **Yes** ☐ **No** ☐

If not, please give reason : \_\_\_\_\_  
\_\_\_\_\_.

### E. Hospitalisation / treatment Details

Name & contact details of doctor first consulted after the accident : \_\_\_\_\_  
\_\_\_\_\_

Name and contact details of other doctor 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	Capital 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.



**MAGMA**  
General Insurance Limited

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

Signature of Insured/claimant

Date

**To be completed by Employer (for group policies)**

This is to certify that:

Mr./Ms \_\_\_\_\_, working as \_\_\_\_\_, permanent Employee Id No. \_\_\_\_\_ covered under Group Personal Accident Policy No. \_\_\_\_\_ was on leave for the period \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_.

Mr./Ms. is covered under the policy for a capital sum insured of Rs. \_\_\_\_\_. The total number of employees on permanent rolls as on the date of accident was \_\_\_\_\_. The above information is true to the best of my knowledge and we agree to provide any further information that may be required.

Signature of Authorised signatory

Date

Name & Designation of Authorized signatory

Company Seal

**Documents to be attached to the claim form:**

- Police Report/Panchnama
- Post Mortem Report
- Death Certificate
- Copies of record of treatment including X rays, investigation reports
- Cash memos, Bills and receipts in case medical expenses are covered
- Any other document as may be required

**Medical Attendant's Certificate**

Name of patient : \_\_\_\_\_

Occupation : \_\_\_\_\_

How long have you known this patient \_\_\_\_\_

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



**MAGMA**  
General Insurance Limited

Kindly state the nature of and extent of injuries : \_\_\_\_\_  
\_\_\_\_\_

Is the injury consistent with claimant'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** ☐

If yes, when, nature and duration of the; \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was the patient under the influence of intoxicants or drugs at the time of accident :



**MAGMA**  
General Insurance Limited

**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, If yes, give details and percentage of disability : \_\_\_\_\_

In case of death of insured person, kindly state the cause of death : \_\_\_\_\_.

**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

\*\*\*\*\*

