

HDFC ERGO General Insurance Company Limited



INDIVIDUAL PERSONAL ACCIDENT - CLAIM FORM

Claimant's Statement

Form 'A'

INSURED INFORMATION

Insured's Name:

Insured's Address:

Date of Birth: Marital Status: Married Unmarried

Phone No. (Off): Phone No.(Res):

Name and address of employer:

Policy Number: Insured's Occupation:

Does the insured have any other insurance? Yes No

If yes, please list all companies, type of insurance, policy numbers and insurance amounts:

CLAIM INFORMATION

Date of accident: Time and place accident occurred:

Please describe in detail the circumstances of accident:

(attach separate sheet if needed)

Was the accident related to the Insured's occupation? Yes No If so, how?

Please describe the nature of Insured's injuries:

Please list the names and addresses of all treating physicians and hospitals:

Did police or other authorities investigate the accident? Yes No

If yes, please provide name, address and telephone number of all investigating officers and agencies:

CLAIMANT INFORMATION (If different than "Insured Information" above)

Claimant's Name:

Claimant's Address:

Relationship to Insured: Age: Yrs Phone No. (Off):

Phone No.:

In what capacity are you making this claim?

AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by HDFC ERGO General Insurance, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

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.

Date:

Place:

SIGNED(Claimant or authorized person)

ACCIDENTAL INJURY - CLAIM FORM

Insured's Statement

Form 'B'

INSURED INFORMATION

Insured's Name:

Insured's Address:

Phone No. (Off): Phone No.(Res):

Policy Number:

CLAIM INFORMATION

Date of accident: Time and place accident occurred:

Please describe in detail the circumstances of accident: (attach separate sheet if needed)

Was the accident related to the Insured's occupation? Yes No If so, how?

Please describe the nature of Insured's injuries:

Please list the names and addresses of all treating physicians and hospitals:

Did police or other authorities investigate the accident? Yes No

If yes, please provide name, address and telephone number of all investigating officers and agencies:

Please list the names and addresses of all treating/consulting physicians or other healthcare providers:

Name:

Street Address:

City: State: PinCode: Phone:

If hospitalized, please provide name and address of hospital(s) where treatment was received:

Do you have any other insurance that may provide coverage for this accident or loss? Yes No

If yes, please identify name, address, and policy number of all other insurance:

AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other person who may have knowledge regarding this claim to release any information requested regarding this claim and the loss reported. I understand this information will be used by HDFC ERGO General Insurance, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

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.

Date:

Place:

Signed (Insured or authorized person)

CERTIFICATION OF NO OTHER INSURANCE

I, _____ hereby certify that I have no other accident or health insurance or any other insurance covering this loss.

Date:

Place:

Signed (Insured or authorized person)

HOSPITAL CASH PLAN - CLAIM FORM

(N.B. To be filled in by the Insured Policy holder, or Insured's authorised representative enjoying power of attorney. Issuance of this claim form is not be taken as admission of liability)

Form 'C'

INSURED INFORMATION

Name of Policy holder:

Name of Employee/Member:
(For group insurance policy only)

Policy Number: Insured No./Certificate No. (If applicable):

Name of Patient:

Occupation: I.D. Card No.: Date of Birth:

Relationship to the Policy holder: Self Spouse Child Staff/ Member Dependent

1. Have you had any prior treatment for this or related conditions? Yes Yes

Doctor's Name:

Address:
 Date:

2. Are you making any other insurance claim as a result of this hospitalization/surgery? Yes Yes

Name of Insurance Company:

Policy Number:

3. (a) Was the hospitalization/surgery a result of an accident? Yes Yes

(b) Date of accident: Time and place accident occurred:

Please describe in detail the circumstances of accident:
 (attach separate sheet if needed)

4. Hospitalization

Name of hospital:

Date of admission: Date of Discharge:

I/We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and I/We agree if I/We have made, or in any further declaration the Company may require in respect of the said claim, shall make any false or fraudulent statement, or any suppression or concealment the Policy shall be void and all rights to recover thereunder in respect of past or future claims shall be forfeited

AUTHORIZATION

I HEREBY AUTHORIZE on behalf of the patient: (1) Any employer, medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organisation, institution or person, that has any records or knowledge of the patient and/or who has attended or may hereafter attend the patient to disclose such information to HDFC ERGO General Insurance Company; (2) HDFC ERGO General Insurance Company or any of its appointed medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of the patient in relation to this claim. This authorization shall bind the patients successors and remains valid notwithstanding death or incapacity. A photocopy of this authorization shall be as valid as the original.

Date:

Place:

Signature of Patient

ACCIDENTAL INJURY - CLAIM FORM

Form 'D'

Accidental Injury Hospital Cash Claim (Accident or Sickness) Attending Physician's Statement

INSURED INFORMATION

Insured's Name:

Insured's Address:

Date of Birth: DD MM YY YY YY YY Marital Status: Married Unmarried

Phone No. (Off): Phone No.(Res):

Name and address of employer:

Policy Number: Insured's Occupation:

CLAIM INFORMATION

Date of accident: DD MM YY YY YY YY Date of first treatment: DD MM YY YY YY YY

Please describe in detail the nature of the Insured's injuries:

Was the accident related to the Insured's occupation? Yes No If so, how?

Was the Insured hospitalized? Yes No

If yes, please list the names and addresses of all hospitals and all admission/discharge dates:

Did the Insured have any injury or illness prior to the accident that contributed to the accident or to the Insured's present condition? Yes No

If yes, please describe:

Were any surgical procedures performed? Yes No

If yes, please list all procedures, and dates performed:

What are the Insured's current subjective symptoms?

What are the objective findings? (please include results of current x-rays, labtests, etc.)?

Dates of total disability: From: DD MM YY YY YY YY To: DD MM YY YY YY YY

Dates of partial disability: From: DD MM YY YY YY YY To: DD MM YY YY YY YY

Date Insured able to return to work: DD MM YY YY YY YY

Was the Insured seen by any other physician? Yes No

If yes, please list the names and addresses of all other physicians:

ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician:

Insured's Address:

Phone No.:

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.

Date: DD MM YY YY YY YY

Place:

SIGNED (Attending Physician)

ACCIDENTAL INJURY - CLAIM FORM

Form 'E'

Accidental Death Claimant's Statement

INSURED INFORMATION

Insured's Name, Address, Date of Birth, Marital Status, Phone No., Name and address of Last Employer, Policy Number, Insured's Occupation, Did the Insured have any other accident or life insurance?

CLAIM INFORMATION

Date of accident, Time and place accident occurred, Please describe in detail the circumstances of accident, Was the accident related to the Insured's occupation?, Please describe the cause of the Insured's death, Did police or other authorities investigate the accident?, Was an autopsy performed?, Was a coroner's inquest held?

CLAIMANT INFORMATION

Claimant's Name, Age, Relationship to Insured, Claimant's Address, Phone No., In what capacity are you making this claim?

*Please provide a certified copy of all documents supporting your authority (e.g., Succession Certificate, Notarised Affidavit, Notarised will, etc.) I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported.

Date: Place:

SIGNED(Claimant or authorized person)

Downloaded from www.insureatlick.com - Broker : Loyal Insurance Brokers Ltd.

Individual Personal Accident – Claim Document Checklist

(Additional documents if required will be requested by the insurer)

Accidental Hospitalization

- Duly filled and signed Claim Form
- FIR Copy
- Hospital Indoor Case Papers
- Discharge Card
- Hospital Bills, Medicine Bills, Prescriptions
- Passport, PAN Card, Aadhar card and Address Proof (KYC Documents)

Personal Accident - Death

- Duly filled and signed Claim Form
- FIR Copy
- Post Mortem Report
- Cause of death Certificate from treating doctor
- Death Certificate
- Passport, PAN Card, Aadhar card and Address Proof (KYC Documents)

Personal Accident – Permanent Disability

- Duly filled and signed Claim Form
- FIR Copy
- Disability Certificate from treating doctor
- Hospital Indoor Case Papers
- Passport, PAN Card, Aadhar card and Address Proof (KYC Documents)

* Please send the cancelled cheque of insured /nominee for NEFT / RTGS transfer. If claim becomes payable.

HDFC ERGO General Insurance Company Limited



Consent for Mode of Claim Payment

Name of Insured

Policy Number

Claim Number

Beneficiary Name

Mode of Payment Cheque Fund Transfer

(Please tick for mode of payment)

(All Fields are Mandatory in case of Fund Transfer)

Insured's Name as per Bank Account

Bank Account Number

Branch Name

IFSC Code

Email address

Attachments
In Support of Bank Details
(Please tick the type of proof submitted)

Cancelled Cheque

Bank Passbook Copy

Declaration: I Mr./ Mrs/ Ms. _____
undersigned, legal beneficiary of the above claim, declare that all details mentioned in this form are true and I agree to the mode of payment against the particular claim number mentioned above.

Downloaded from www.insureatlick.com - Broker : Loyal Insurance Brokers Ltd.

Signature of Beneficiary
Stamp Required in case of Company

Date: