Hospital Cash/Medical Expenses

Claim Form

TATA AIG INSURANCE
WITH YOU ALWAYS

Tata AIG General Insurance Company Limited: A-501, 5th Floor, Building No.4, Infinity Park, Gen. A.K. Vaidya Marg, Dindoshi, Malad (East), Mumbai 400 097

IMPORTANT:

1. Issuance of this form is not an admission of Liability or a waiver of the terms, conditions and exceptions of the insurance contract.
2. If the space provided is insufficient, please attach additional sheets.

Claim No. **Policy No.**

1. PERSONAL DETAILS

Details of Insured Name (First Name / Middle Name / Surname)

Address

City

State PIN

Phone (O) (R)

Fax Mobile

E-mail

Date of Birth (D D M M Y Y Y Y) Designation

2. DETAILS OF ACCIDENT

Time and Date (D D M M Y Y Y Y)

Place and Location (full address)

City

State PIN

Phone (O) (R)

Fax Mobile

E-mail

3. DETAILS OF INJURY

Please describe details of injury sustained _____

Specify the injured parts of body _____

4. TREATMENT DETAILS

Name of the Attending Doctor

Phone (O) (R)

Fax Mobile

E-mail

Date (s) of consultation (D D M M Y Y Y Y)

Name of the Hospital(s) (If hospitalized)

Address

City

State PIN

Phone (O) (R)

Fax Mobile

E-mail

Period of hospitalization : From To

Diagnosis / Surgery

5. AMOUNT OF EXPENSES

a) Medical Expenses

Sl No	Date	Details	Amount
	D D M M Y Y Y Y		
	D D M M Y Y Y Y		
	D D M M Y Y Y Y		
	D D M M Y Y Y Y		
	D D M M Y Y Y Y		
	D D M M Y Y Y Y		
	D D M M Y Y Y Y		
	D D M M Y Y Y Y		
	D D M M Y Y Y Y D D M M Y Y Y Y		

Please attach a separate sheet if the space is insufficient.

b) In hospital cash (If covered)

From	To	Amount

Have the Police Authorities been informed of this accident? YES ☐ NO ☐

I hereby declare that I have suffered injuries as described above and all the details given are ABSOLUTELY TRUE AND CORRECT. I hereby agree to forfeit all my rights to compensation if any of the foregoing facts and /or details are found to be false or incorrect. I further authorise the hospital, doctor diagnostic laboratory, organisation, establishment or any other body or person dealt with in the course of this claim to give any information or document sought for by the Insurance Company.

Date: _____

Place: _____

_____

Signature of the Insured

ATTENDING PHYSICIAN'S STATEMENT

PLEASE ANSWER ALL QUESTIONS

1 Name of Injured Person:

Age of Injured Person:

2 Address:

3 **Nature of the Accident and Details of Injuries Sustained:**

_____

_____

4. Does the Cause of Accident as stated by the Claimant tally with the Injuries noticed by you?

_____

_____

5. Are the injuries solely due to the accident or traceable to any previous injuries / disease / infirmities?

_____

_____

6. Was the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition.

_____

7. Was the Claimant hospitalized? If so for what period? _____

8. What treatment was given and Operations performed? _____

9. Give all dates of treatment : Home: From _____ To _____

Clinic/Hospital: From _____ To _____

10. Was he under the influence of intoxicants or drugs at the time of accident ? _____

11. Are you his usual medical Attendant ?

If you have treated him for any previous illness or injury, Please give details.

_____

12. Have other Doctors been in Attendance or Consultation? If yes, Please give details.

_____

13. Has this accident been reported to the Police Authorities? If yes, Case No: _____ Police Station _____

14. Is this claimant Totally Disabled from each and every occupation? _____

15. (a) How long was or will the claimant be totally disabled from current occupation? From _____ To _____

(b) Estimated date of return to Work. _____

16. What is the Prognosis? _____

Doctor's Signature & Stamp _____ Date: _____ Regn No: _____

Doctors Name: _____

Address: _____

Phone No. _____

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For more information visit us at; Email us at customersupport@tata-aig.com or visit www.tataaiginsurance.in
Contact us on our 24 hour Toll Free Helpline at 1800 266 7780 or 1800 22 9966 (only for senior citizen policy holders)