

Maharaksha Claim Form

Claim Form



WITH YOU ALWAYS

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. No claim will be admitted without a Medical Report (Attending Physician's Statement) as per format (Page 4) to be obtained at claimant's expense.

Claim No.

Policy No.

PERSONAL DETAILS

Name a) Insured

b) Claimant

Address

City

State PIN

Phone (O) (R)

Fax Mobile

E-mail

Date of Birth Occupation

(Please be available at this place where our representative may call on you)

2. ACCIDENT DETAILS

Time and Date

Place and Location (full address)

Cause Description

3. INJURIES/CLAIM DETAILS

A. Fractures/Dislocation/Burns

Part of Body which is Injured:

Hip or Pelvis <input type="checkbox"/>	Thigh or Heel <input type="checkbox"/>	Lower Leg <input type="checkbox"/>	Skull <input type="checkbox"/>
Clavicle <input type="checkbox"/>	Ankle <input type="checkbox"/>	Elbow/s <input type="checkbox"/>	Arm (upper) <input type="checkbox"/>
Arm (Lower) <input type="checkbox"/>	Shoulder Blade <input type="checkbox"/>	Knee cap <input type="checkbox"/>	Sternum <input type="checkbox"/>
Hand <input type="checkbox"/>	Foot <input type="checkbox"/>	Spine <input type="checkbox"/>	Lower Jaw <input type="checkbox"/>
Rib/s <input type="checkbox"/>	Cheekbone <input type="checkbox"/>	Coccyx <input type="checkbox"/>	Upper Jaw <input type="checkbox"/>
Nose <input type="checkbox"/>	Toe/s <input type="checkbox"/>	Finger/s <input type="checkbox"/>	<input type="checkbox"/>

Type of Injury:

Compound Fracture <input type="checkbox"/>	Complete Fracture <input type="checkbox"/>	Colles Fracture <input type="checkbox"/>
Compression Fracture <input type="checkbox"/>	Pedicle Fracture (Transverse & Spinous) <input type="checkbox"/>	Neurological damage (due to fracture) <input type="checkbox"/>
Other Vertebral Fractures <input type="checkbox"/>	2 nd Degree Burns <input type="checkbox"/>	3 rd Degree Burns <input type="checkbox"/>
Dislocations <input type="checkbox"/>	Internal Injury resulting in abdominal or thoracic surgery <input type="checkbox"/>	

B. In-Hospital Indemnity - Accident Only

Details of Accident:

Type of Injury: Name of Hospital:

Address:

Phone Nos.: Attending Doctor:

Date of Admission: Date of Discharge:

ATTENDING PHYSICIAN'S STATEMENT

PLEASE ANSWER ALL QUESTIONS

1 Name of Injured Person: [grid]

2 Age [grid]

3 Address [grid]

4 Details of Injury: Fractures/Burns/Dislocation

A. Nature of the Accident

B. Part of Body which is Injured:

- Hip or Pelvis, Thigh or Heel, Lower Leg, Skull, Clavicle, Ankle, Elbow/s, Arm (upper), Arm (Lower), Shoulder Blade, Knee cap, Sternum, Hand, Foot, Spine, Lower Jaw, Rib/s, Cheekbone, Coccyx, Upper Jaw, Nose, Toe/s, Finger/s

C. Type of injury: (please specify type of fracture, Degree of burns etc.)

[lines for answer]

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

[lines for answer]

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

[lines for answer]

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

[line for answer]

8. Was the Claimant hospitalized? If so for what period? [line]

9. What treatment was given and Operations performed? [line]

10. Give all dates of treatment : Clinic/Hospital: From [line] To [line] Home: From [line] To [line]

11. Was he under the influence of intoxicants or drugs at the time of accident ? [line]

12. Are you his usual medical Attendant ?

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

[line for answer]

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

[line for answer]

14. Has this accident been reported to the Police Authorities? If yes, Case No: [line] Police Station [line]

15. Is this claimant Disabled from performing any of the following activities:

- Mobility, Continenace, Dressing, Toileting, Eating

16. How long was or will the claimant be totally disabled? From [line] To [line]

17. What is the Prognosis? _____

Doctor's Signature _____

Date: _____

Regn No: _____

Qualifications: _____

Doctors Name: _____

Address: _____

Phone No. _____

Tata AIG General Insurance Company Limited

Registered office: Peninsula Business Park, Tower A, 15th Floor, G. K. Marg, Off Senapati Bapat Road, Lower Parel, Mumbai - 400 013.

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)
Insurance is the subject matter of the solicitation