

Toll Free No. 1800 266 3202



CLAIM FORM

INDIVIDUAL PERSONAL ACCIDENT INSURANCE

Claim Form

Individual 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 MHDH.

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 _____

Address where a representative on behalf of **MAGMA HDI GENERAL INSURANCE COMPANY LIMITED** 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 not, kindly state the reasons

Are there any witnesses to the accident **Yes** **No**

If yes, kindly provide name(s) and contact details

Was Post-mortem conducted **Yes** **No**

If yes, kindly attach a copy of the Report

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. Hospitalization / Treatment Details

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

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 HDI GENERAL INSURANCE COMPANY LIMITED** 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 HDI GENERAL INSURANCE COMPANY LIMITED** 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 _____

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 – Doctor'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?

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 _____
General Insurance Company Ltd.

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
