

Claim Form

Personal Accident Insurance

Claim Form 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 MHDI.

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) : _____

UIN - IRDAN149RP0010V02201314

Address where a Medical Practitioner on behalf of MHDH 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 :

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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 MHDI being able to refuse to pay a claim.

I authorize any hospital, physician or any other medical provider who has attended or examined me/insured person to furnish MHDI 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**

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 :

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____/____/____

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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

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