Magma HDI General Insurance Company Limited
Regd. Office: Development House, 24 Park Street, Kolkata – 700 016.
Website: www.magmahdi.com | Toll Free No. 1800-266-3202 | IRDAI Registered No. 149 |
CIN: U66000WB2009PLC136327

UIN - IRDAN149RP0008V02201314

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) **:** _____

Address where a Medical Practitioner on behalf of MHDI 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 :

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_____/_____/_____

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