Magma HDI General Insurance Company Limited
Regd. Office : 24 Park Street, Kolkata – 700 016
P : + 91 033 - 4401 7304 / 7477, F : 91 033 - 4401 7471

CLAIM FORM

SARAL SURAKSHA BIMA, MAGMA HDI

UIN: MAGPAIP21642V012021

MAGMA HDI General Insurance Company Ltd.

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Claim Form

Saral Suraksha Bima, Magma HDI

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/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. Details of Dependent Children (For claim under Education Grant Benefit)

Name of Dependent Child	Age of Dependent Child	Education Pursuing	Name of School/College/Institute

Documents required:

Admission card
ID card
Last year's Mark sheet
Letter from school, college, institute affirming he/she is studying in their organization.

G. 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

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H. 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** ☐

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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

_____

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.

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Signature* Qualification Reg.No.

Name : Address

Date

*Kindly Affix official seal/stamp

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