

GROUP PERSONAL ACCIDENT CLAIM FORM



WITH YOU ALWAYS

A&H Claims Department, Tata AIG General Insurance Co. Ltd., 7th and 8th Floor, Romell Tech Park, Cama Industrial Estate, Western Express Highway, Goregaon(E), Mumbai, Maharashtra 400063

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 as per format to be obtained at claimant's expense.

Claim No.

Policy No.

1. PERSONAL DETAILS

Name (In block letters)

a) Insured

First Name										Middle Name										Surname									

b) Claimant

First Name										Middle Name										Surname									

Address

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Age						Employee Designation																									
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Employee Date of Joining

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2. ACCIDENT DETAILS

Time and Date

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Place and Location
(full address)

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Cause Description

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3. DETAILS OF INJURIESSpecify injured
parts of body

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Total disablement
(if any)

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Percentage

%

(In words)

4. WITNESSES

1) Name

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Address

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Address

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City																													
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5. TREATMENT DETAILS

A. Name of Casualty Doctor

Address

Phone

Registration No.

B. Name of Family Doctor

Address

Phone

Registration No.

C. Name of Hospital

Address

Phone

6. CONTACT DETAILS

Address where available

Phone

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

7. CONFINEMENT

A. Total Confinement

From _____ To _____

(This should be the actual days when fully confined to bed on Medical Advice)

B. Partial Confinement

From _____ To _____

(This should be the days when partially confined to bed)

8. AMOUNT OF CLAIM

A. Total Temporary Disablement

Amount (Rs) _____

B. Permanent Disablement

Amount (Rs) _____

C. Medical Expenses

Amount (Rs) _____

D. Death

Amount (Rs) _____

9. PAST HISTORY

A. Have you made any claims in the PAST ?

☐ YES ☐ NO

B. If YES, please give details including accident and Insurance details

10. Are you insured under any other policy ?

☐ YES ☐ NO

If YES, please give full details

11. Have the Police Authorities been informed of this accident?

☐ YES ☐ NO

If YES,

Case No. _____

Police Station _____

I hereby declare that I have suffered injuries as described above and all the details given are **ABSOLUTELY TRUE AND CORRECT**. I hereby agree to forfeit all my rights to compensation if any of the foregoing facts and / or details are found to be false or incorrect. I further authorise the hospital, doctor diagnostic laboratory, organisation, establishment or any other body or person dealt with in the course of this claim to give any information or document sought for by the Insurance Company.

Date: _____

Place: _____

Signature of the Insured

ATTENDING PHYSICIAN'S STATEMENT

PLEASE ANSWER ALL QUESTIONS

- | | |
|----------------------------|-------|
| 1. Name of Injured Person: | |
| 2. Age | |
| 3. Address | |
| | Phone |

 4. Nature of the Accident and Details of Injuries Sustained _____

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

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

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

 8. Was the Claimant hospitalized? If so for what period? _____

 9. What treatment was given and Operations performed? _____

 10. Give all dates of treatment : Clinic/Hospital: From _____ To _____
 Home : From _____ To _____

 11. Was he under the influence of intoxicants or drugs at the time of accident? _____

 12. Are you his usual medical Attendant? _____

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

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

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

 15. Is this claimant Totally Disabled from each and every occupation? _____

 16. (a) How long was or will the claimant be totally disabled from current occupation?
From _____ To _____
(b)How long was or will the claimant be partially disabled from current occupation?
From _____ To _____
(c) Estimated date of return to Work. _____

 17. What is the Prognosis? _____

Doctor's Signature

Date: _____ Regn No: _____

Doctors Name

Address and Phone No.

Phone