

HDFC General Insurance Limited (Formerly L&T General Insurance Company Limited)

An HDFC ERGO Company

Claim Form - my:health Group Personal Accident Insurance

Important:

- 1. Please fill the form in BLOCK LETTERS. All details with* are mandatory.
- 2. Please answer all the questions completely. If a particular question is not applicable to you and/or your business please mark that question as not applicable "N/A".
- 3. Kindly contact the Company's Office or Agent for any doubts or clarifications on the claim form.
- 4. Issuance of this form is not an admission of liability or a waiver of the terms, conditions and exceptions of the insurance contract.

Policy No.: Certificate No.: Claim No.: Claim No.:					
Name of the Insured (Group Name/Corporate Name): FILIRISIT					
(I) PERSONAL DETAILS					
NAME (In block letters)*:					
a) Insured FIIRSTI MIIDDLE LAST					
b) Claimant c) Relationship (if Insured and claimant are different)					
Address:					
City: State: State:					
Occupation: Age:					
(II) DETAILS OF ACCIDENT					
Date*: D D M M Y Y Y Y Time*: H H : M M					
Place and Location (Full Address)*:					
Cause description of accident*:					
(III) DETAILS OF INJURIES					
Specify Injured Parts of Body. If injury sustained in eye or limb, please specify left or right:					
(IV) WITNESSES					
NAME (In block letters)*: FIIRSTI MIIDDDLE LAST					
Address:					
City:					
(V) TREATMENT DETAILS					
Attending/treating Doctor					
Name: F R S T M D D L E					
Address: Phone No.: Phone No.:					
Family Doctor					
Name: F R S T					
Address: Phone No.:					
Hospital(s)					
Name: F R S T M D D E					
Address: Phone No.:					
(VI) CONTACT DETAILS – where and when can our representative may visit you, if necessary.*					
Address where Available:					



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(VII) Please indicate the appropriate section under which you are claiming along with the amount*

	Coverage				Amou	Amount (Rs.)		
	Total Temporary Disablement							
	Permanent Total Disablement							
	Permanent Partial Disablement							
	Accidental Death							
	Add on covers 1)	Add on covers 1)						
	2)							
	3)							
VIII) PERIOD OF DISABILITY - applicable for claim under Temporary total disability*(The period should be the actual days when fully confined to bed on Medical Advice)								
	From: D D M M Y	/ Y Y Y То: D	D M M Y Y Y Y					
XI)	PAST INSURANCE HISTOR	RY*						
	Have you made any clain	ms in the past ?				YES	NO	
	• If YES, please give details	s including accident and Ins	urance details					
	Name of Insurance co.	Policy no.	Capital Sum Insured	Nature of claim		Status of the	claim	
X) Are you currently insured under any other Policy?*							NO	
	If YES, please give full details							
	Name of Insurance co.	Policy no.	Capital Sum Insured	Details of claim lodged		Status of th	e claim	
XI)	Have the Police Authoriti	ies heen informed of this	accident? If yes, please specify the	name of the Police static	on and t	the FIR		
, (1)	nave the Folice Authoriti	ies been informed of this	decident. If yes, please speeny the	name of the Fonce State	on and t	ine i iii		
	I/We hereby declare that the foregoing statements made by me/us are true in all respects, that I/We have not attempted to conceal from the Company anything with which it ought to be made acquainted and that if I/We have made or in any further declaration the Company may require shall make any false							
	or fraudulent statement or untrue averment whatever, the policy shall be void and my/our right to compensation forfeited. I /We are willing if required, to make and provide to the company a statutory declaration of the whole of the foregoing statement or of any other statement made in connection with this claim							
	Date:							
	Place:							
	Signature of the Insured/Insured Person						erson	



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ATTENDING PHYSICIAN'S STATEMENT

PLE	PLEASE ANSWER ALL QUESTIONS					
1.	. Name Of the Injured Person: FIIRST MIIDDDLE LAST Age: L					
2.	Nature of the Accident and Details of Injuries sustained. Please specify the parts of the body. If injury sustained in eye or limb, specify left or right.					
3.	Does the Cause of Accident as stated by the Claimant tally with the Injuries noticed by you?					
4.	Are the Injuries solely due to the accident or traceable to any previous injuries/ disease/ infirmities?					
5.	Was the Injured Person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition.					
6.	. Was Injured Person under the influence of intoxicants or drugs at the time of accident ?					
7.	Was the Injured Person hospitalized? If so for what period?					
	From: D D M M Y Y Y Y Y To: D	DIMIMIYIYIY				
8.	Details of treatment and Operations (if any) performed					
9.	Give all dates of treatment:					
	Home: From: DIDIMIMIYIYIY To: DIDIMIMIYIYIYIY					
	Clinic/ Hospital: From: DIDIMIMIYIYIY To: DIDIMIMIYIYIYI					
10.	Please fill one of the following to indicate the nature of the disability.					
	Nature of disability as per the attending doctor	Please specify against the appropriate nature of disability				
	Total Temporary Disablement					
	Permanent Total Disablement					
	Permanent Partial Disablement					
11. In case of Temporary Total disability how long was or will the claimant be totally disabled from current occupation?						
From: DIDIMIMIYIY I YIYIY To: DIDIMIMIYIYIYIY						
	Doctor's Name:					
	Rean No :	Doctor's Signature				

Date:_

Address: