PARIVAR SURAKSHA BIMA – SECTION I
Claimant's Statement

INSURED INFORMATION

Insured's Name________________________________ Date of Birth ___/____/____ Marital Status _____

Insured's Address
____

Policy Number __________________________ Insured's Occupation (at time of death)
____

Certificate Number_________________________ Membership Number_____________________________________

Did the Insured have any other accident or life insurance? _________ If yes, please list all companies, policy numbers and insurance amounts:__
____

ACCIDENT INFORMATION

Date of accident ______/_______/______ Time and place accident occurred____

Please describe in detail the circumstances of accident (attach separate sheet if needed):

____

____

Was the accident related to the Insured's occupation? ___________________ If so, how?
____

Please list the names and addresses of all treating physicians and hospitals:____

____

Date of Admission: _______________ Date of Discharge: ___________________

Hospitalisation Expenses:____________

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Did police or other authorities investigate the accident? ____ If yes, please provide name, address and telephone number of all investigating officers and agencies:

____

CLAIM INFORMATION FOR DEATH

Please describe the cause of the Insured's death:

____

Was an autopsy performed?______ If yes, please provide name and address of Medical Examiner____________________

____

____

Was a coroner's inquest held? _______If yes, what was the determination?_______________________________________

CLAIM INFORMATION FOR DISABILITY

Nature of Injuries: ______________________________________

Has the Accident resulted into Loss of Hand / Hands or Loss of Foot / Feet / Eye / Eyes / Permanent Total Disability of any other type which may prevent the Insured Person engaging in or being occupied with or giving attention to any employment or occupation whatsoever? If yes, please list details

____

Please also attach the Certificates & Reports from the Hospital Authorities or Attending Civil Surgeons certifying the Permanent Total Disablement.

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CLAIMANT INFORMATION

Claimant's Name____ Age_______ Relationship to Insured______________

Claimant's Address____ Phone No. (H)_____________________________

____ Phone No. (W)_____________________________

In what capacity are you making this claim? _____ Beneficiary ______ Executor* ______ Administrator* _____ Guardian* _____Trustee* _____Assignee*

***Please provide a certified copy of all documents supporting your authority (e.g., Succession Certificate, Notarised Affidavit, Notarised will, etc.)**

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by HDFC Chubb General Insurance Co. Ltd., or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.
I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud and I agree that if I have made, or in any further declaration the Company may require in respect of the said claim, shall make any false or fraudulent statement, or any suppression or concealment, the Policy shall be void and all rights to recover hereunder in respect of past or future claims shall be forfeited.

Place:

____

DATE ____/____/____ **SIGNED (Claimant or authorized person)**

This is to certify that the above mentioned claim lodged by the Insured Person / Claimant is genuine and the same is recommended for reimbursement.

Authorised Signatory **Place:**

Name of the Policyholder & Seal: **Date:**

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PARIVAR SURAKSHA BIMA – SECTION II

(N.B. To be filled in by the Insured, or Insured's authorised representative enjoying power of attorney. Issuance of this claim form is not be taken as admission of liability under the policy on the part of the insurer)

PART I – Insured's Information

Name of Policyholder:	
Name of Member of Insured Family :	Policy No. ____________________
Membership No.:__________________ Certificate No. ___________________ (If applicable)	

PART II – Claimant Information

Name of Patient:	I.D. Card No.:
Occupation :	Date of Birth: Present completed age: ___

Address and phone number :
____

Relationship to the Policyholder: ☐ Member ☐ Spouse ☐ Child ☐ Dependent Mother ☐ Dependent Father

(1) Nature of sickness /disease/injury claimed for :

____

Date on which Injury was sustained or disease or illness first detected : ______________________________

Date of first consultation : ____________________________________

Name, Address, Telephone No. of Doctor Consulted : ____

Qualification of the Doctor Consulted : ____

(2) Have you had any prior treatment for this or related conditions?

NO ☐ YES ☐ Doctor's Name : ________________________________

Qualification : ________________________________

Address & Telephone: ________________________________

____

Date(s) : ________________________________

(3) Are you making any other insurance claim as a result of this hospitalization/surgery?

NO ☐ YES ☐ Name of Insurance Company : ____________________________

Policy No. : ____________________________

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(4) Was the hospitalization/surgery a result of an accident?

NO ☐ YES ☐ Place of Accident ________________ Date of Accident ______________

(5) Is the claim is for Maternity Expense Benefit: NO ☐ YES ☐

If so, is it your ☐ first delivery ☐ second delivery ☐ third delivery

Are you already having 2 children: NO ☐ YES ☐

(6) Details of hospitalisation

Name of Hospital / Nursing Home	Address	Date of Admission	Date of Discharge

(7) CLAIM QUANTUM

Date	Nature of expenses incurred	Billed By	Amount (Rs)
		Total	

(If space is insufficient, please attach separate list)

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In support of the above claim, I enclose the following original documents (Please tick)

☐ Hospital Discharge Card
☐ Bills, Cash Memos, Receipt from Hospitals
☐ Cash Memos, Receipts from Pharmacists, Pathology and Investigation Centres
☐ Bills, Cash Memos, Receipts from Attending Doctors, Surgeons, Anesthetists
☐ Doctor's prescriptions for medicines, pathological tests, hospitalisation, surgery, physiotherapy
☐ Any other documents. Please specify

____

____

I/We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and I/We agree that if I/We have made, or in any further declaration the Company may require in respect of the said claim, shall make any false or fraudulent statement, or any suppression or concealment the Policy shall be void and all rights to recover thereunder in respect of past or future claims shall be forfeited

AUTHORISATION

I HEREBY AUTHORISE on behalf of the patient: (1) Any employer, medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organisation, institution or person, that has any records or knowledge of the patient and/or who has attended or may hereafter attend the patient to disclose such information to HDFC Chubb General Insurance Company; (2) HDFC Chubb General Insurance Company or any of its appointed medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of the patient in relation to this claim. This authorisation shall bind the patient's successors and remains valid notwithstanding death or incapacity. A photocopy or facsimile copy of this authorisation shall be as valid as the original.

Date: **Signature of Patient**

Place:

This is to certify that the above mentioned claim lodged by the Insured / Claimant is genuine and the same is recommended for reimbursement.

Authorised Signatory **Place:**

Name of the Policyholder & Seal: **Date:**

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ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician: ____ Phone No. _________
Address: ____

I certify that the above named patient ________________________, was seen by me on __________ and has been fully cured of the sickness/injury claimed for, which first incurred on _________________

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.
SIGNED (Attending Physician) ____ DATE ____/____/____

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