Personal Accident Insurance

How to file a Claim

- In case of any event leading to a claim under the policy, please call our Toll-free Number 1800-2-700-700
- Our Claims Service Representative will guide you on the claim procedures and documents Required
- Complete the claim form relevant to the nature of loss as indicated below.
- Attach the documents mentioned against the claim type

For Accidental Injury Claims

1. Claim form as per 'Form A+ D'
2. Police FIR, if accident is reported to Police
3. Medical papers, pathology reports, X-ray reports, as applicable
4. For Permanent Disability Claims – disability certificate from reputed surgeon or Municipal Hospital
5. For Temporary Total Disability Claims-sick leave certificate from Employer
6. Attending Physician's statement as per 'Form D'

- Our Claims Service Representative may visit you in the Hospital or at Home to personally collect claim documents.
- Documents, in addition to those mentioned above maybe called for, depending on the nature of accident and claim lodged.

- Please retain a copy of the documents sent for your records.

HDFC ERGO General Insurance Company Limited

Form 'A'

Accidental Injury Claim

Claimant's Statement

INSURED INFORMATION

Insured's Name_____ **Date of Birth** ___/____/____ **Marital Status** ____

Insured's Address _____ **Phone No. (Off)**_____

_____ **Phone No. (Res)**_____

Name and address of employer

_____

Policy Number _____ **Insured's Occupation**

_____

Does the insured have any other insurance ? _____**If yes, please list all companies, type of insurance, policy numbers and insurance amounts:**_____

_____

_____

_____

CLAIM 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 describe the nature of Insured's injuries:_____

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

_____
_____

_____
_____

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

_____
___

CLAIMANT INFORMATION (If different than "Insured Information" above)

Claimant's Name_____ **Age**_____ **Relationship to Insured**_____

Claimant's Address_____ **Phone No. (Off)** _____

_____ **Phone No. (Res)**_____

In what capacity are you making this claim?
_____

AUTHORIZATION

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 ERGO General Insurance, 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.

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

HDFC ERGO General Insurance Company Limited

Accidental Injury

Form 'D'

Attending Physician's Statement

INSURED INFORMATION

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

Insured's Address_____ **Phone No. (H)**_____

_____ **Phone No. (W)**_____

Name and address of employer

_____

Policy Number_____ **Insured's Occupation**

_____

CLAIM INFORMATION

Date of accident: ____/ ____/____ **Date of first treatment:** _____/_____/_____

Please describe in detail the nature of the Insured's injuries,

_____

_____

_____

_____

Was the accident related to the Insured's occupation? _____ **If so, how?**

_____

Was the Insured hospitalized? _____ **If yes, please list the names and addresses of all hospitals and all admission/discharge dates:**

_____

_____

_____

_____

Did the Insured have any injury or illness prior to the accident that contributed to the accident or to the Insured's present condition? ____

If yes, please describe:

_____

_

_____

_____

Were any surgical procedures performed? _____ **If yes, please list all procedures, and dates performed:**

_____

_____

_____
_____

What are the Insured's current subjective symptoms?

_____
_____
_____

What are the objective findings? (please include results of current x-rays, lab tests, etc.,)?

_____
_____
_____

Dates of permanent total disability: **Dates of temporary total disability:**

From: _____/_____/_____ **To:** ____/____/____ **From:** _____/_____/_____ **To:** _____/_____/_____

Date Insured able to return to work: _____/_____/_____

Was the Insured seen by any other physician? _____ **If yes, please list the names and addresses of all other physicians:** _____

_____
_____

ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician: _____ **Phone No.** _____

Address:

_____
_____

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.

SIGN WITH STAMP (Attending Physician) _____
DATE