

## FUTURE GENERALI GROUP PERSONAL ACCIDENT - CLAIM FORM

Policy No:		Claim no:	
Employee No:			
1. Details of Insured/ Claimant			-
Name a) Insured/ Company : b) Claimant:			
Address :			
	City	y:	Pin:
Occupation:	Date of birth:	Email ID:	
Contact No: R:	Off:	Mobile:	
2. Accident Details			
Date & Time of accident / Occurrence:		Hrs	
Place & Location:			
Description of accident /incidence:			
3. Details of injuries sustained			
In Case of Death: Details of the Nominee - Name & Addres	s:		
Specify injured parts of the body:			
Please specify nature of Disability:			
Please mention Disability percentage in or Percentage: (%)			(In words)
In case of Confinement/ Away from work Date of resuming duties		: FromTo	)
4. Has the Police been informed about	the accident; If yes p	lease give details	
MLC No:Name & Address of the Police station:	FIR No:		
Name & Address of the Police Station:			

5. Was the injured person under the influence of alcohol/ drugs at the time of accident: YES/ NO

Date:\_



**Group/Insured Stamp** 

		GENERAL GROUP
6. Witnesses Name (s):		
` ,		
	Off:	Mobile:
7. Treatment Details Casualty Doctor	Address :	
Family Doctor	Address :	
Hospital Details	Address :	
8. Policy and Claims H	History	
	Claims in Past ? Yes details including nature of Accid	No dent, Insurance details & Claim amount
	er any other Policy? Yes particulars (Name of company	No , Policy no, Period of insurance, Policy issuing office)
		Declaration
of my/our knowledge ar any further declaration statement, or suppress	nd belief, warrant the truth of th the company may require in re	npany, if required. I/we the above mentioned, do hereby, to the best be foregoing statement in every respect, and if I/we have made, or in spect of the said accident, shall make any false or fraudulent ne policy shall be void and all rights to recover compensation there all be forfeited.
Place:		

Signature of the insured



## **ATTENDING PHYSICIAN'S STATEMENT**

1. Name and Age of insured Person :						
2. Details of Injuries Sustained:						
3. Cause of the injury as reported by the injured person:						
Does the Cause of Accident as s with the Injuries noticed by you?						
5. Are the injuries solely due to the accident ? If No pls. provide the details		: Yes / No				
6. Was the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition?  : Yes / No						
7. Was he/she under the influence	of intoxicants or drugs a	at the time of accident?	Yes/ No :			
8. What treatment was given and operations performed ? :						
9. Give all dates of treatment :	Clinic/Hospital : Home:	From:				
10. Are you his family doctor ? If you have treated him for any Please give details		· :				
11. Have other Doctors been in Attendance or Consultation? :  If yes, Please give details						
12.Has this accident been reported provide	to the Police Authorities	s? If yes please				
MLC No: FIR No	:Police S	Stn name & Address:				
13. Nature of injury suffered by inju		PTD:				
PPD:	<del></del>	TTD:				
14. In case of PTD/PPD kindly state the % of disability:						
15 (a) How long was or will the claimant be totally disabled from current occupation?  From: To:						
(b) Date of resuming to Work :						
16. What is the Prognosis?						

I/We hereby to the best of my/our knowledge and belief, warrant the truth of the above details in every respect.

Doctor's Signature & Stamp: Doctors Name :

Address and Tel. no Regn No: Date: