## **HDFC ERGO General Insurance Company Limited**



### **GROUP PERSONAL ACCIDENT CLAIM FORM**

Claimant's Statement																	Fc	rm'A
INSURED INFORMATION																		
Insured's Name:																		
Insured's Address:															T	П		
Date of Birth:	YYYY	Marita	l Status:		Marr	ied		Unmarı	ied									
Phone No. (Off):				Pho	ne No	.(Res):												
Name and address of employer:															<b>#</b>		<b>#</b>	
Policy Number:			Ins	ured'	s Occ	upation:	$\Box$							$\pm$	$\pm$	$\pm \pm$	十	++
Does the insured have any other insur-	ance?	Yes	No	Jaroa	3 000	apation.												
If yes, please list all companies, type of			J	suran	ce am	ounts:									$\top$	Т	$\top$	$\top$
, , , , , , , , , , , , , , , , , , , ,							$\Box$		П	T			$\top$	$\forall$	十	Ħ	十	$\overline{\Box}$
		С	LAIM IN	FORI	OITAN	N												
Date of accident:	YYYY	Time and	olace acc	ident	occur	red:												
Please describe in detail the circumsta	nces of accider	nt:														Т	$\top$	T
										Ť	1	(atta	ach s	epar	ate s	shee	t if n	eeded)
Was the accident related to the Insured	d's occupation?	Ye	s $\square$	No	If so	, how?					, 			<u>.</u>		Т	$\overline{}$	TT
Vide the decident related to the insure.	25 000apation:				11 00	, 11 <b>011</b> .	$\Box$								$\pm$	$\pm \pm$	$\pm$	+
Please describe the nature of Insured's	s injuries:						$\pm$			+				+	$\pm$	$\pm \pm$	$\pm$	++
Please list the names and addresses of		veiciane ar	nd hoenit	ale:			$\frac{1}{1}$			+					$\pm$	$\pm$	$\pm$	
riedse iist the harnes and addresses to		lysicians an	iu Hospita	ais.						<u> </u>					$\pm$	$\pm$	$\pm$	+
							$\pm$			+					$\pm$	$\pm \pm$	$\pm$	++
Did a line and the south of the investigation		0 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		NI-														
Did police or other authorities investiga	ite the accident	:?	s	No														
If yes, please provide name, address a	ınd telephone n	umber of a	II investiç	gating	office	rs and a	agen	cies:	Щ					Ш	<u></u>	Щ	<u> </u>	<del>                                      </del>
																Ш	$\perp$	
C	LAIMANT INFO	ORMATION	l (If diffe	rent	than "	Insured	l Info	ormatio	n" a	bove	<del>)</del>							
Claimant's Name:															T		$\overline{}$	
Claimant's Address:										Ť					$\equiv$	$\overline{\Box}$	一	
							$\overline{\Box}$		Ħ	$\overline{}$				$\overline{\Box}$	Ť	Ħ	十	$\overline{\Box}$
Relationship to Insured:			Age		Yrs			Phon	e No	. (Of	f):				$\pm$	$\overline{\Box}$	寸	T
Phone No.:			J		_					`	, _							
In what capacity are you making this c	laim2														$\overline{}$	$\top$	$\neg$	$\overline{}$
in what capacity are you making this c										+					$\pm$	$\frac{\perp}{\perp}$	$\pm$	+
AUTHORISATION																		
I authorize any insurance company, physic	cian, hospital or o	other health	care provi	der, o	r any o	ther orga	aniza	ition, inst	itutio	n or p	erso	n tha	t may	/ have	e rec	ords	, doc	uments
or knowledge regarding the insured to rele																		
ERGO General Insurance, or its authorize of this authorization upon request and agr	•	•	-		-		-	-							-			
valid for the duration of this claim.		·		,						J		Ü						
I understand that any person who knowin				ve an	y insur	ance con	npan	y files a	claim	cont	tainin	g an	y mat	eriall	y fals	se, in	com	plete or
misleading information may be subject to p	rosecution for in	surance frau	ıd.															
										Г								
Date:																		
Date: DDDMMMYYYYY										610	2NI⊏⊓	) (CI	aima	nt or	21.ith			erson)

## **HDFC ERGO General Insurance Company Limited**



## **ACCIDENTAL INJURY - CLAIM FORM**

Insured's Stater	nent																																	F	or	m'B
										IN	SU	RE	D II	NF	DRI	MΑ	TIC	N																		
Insured's Name:						$\perp$																						$\perp$					$\perp$			
Insured's Address:						$\perp$																						$\perp$			$\Box$		I			
Phone No. (Off):						$\perp$															Р	hor	ne l	No.	(Re	es):		$\perp$					$\perp$			
Policy Number:						$\perp$																														
										01	Α.		113	0 D I		TIC																				
						_						ΜI									_	_	_	_	_	_	_	_	_	_		_	_	_		
Date of accident:	D D	M M	Л	/   Y	Y Y		Т	ime	an	d p	lac	e a	ccio	dent	t oc	cui	rec	: 		Ш	_	4	_	4	_	_	_	Ļ	Ļ	Ш	ᆜ	<u></u>	<u></u>	Ļ	Щ	<u></u>
Please describe in de	tail the	circun	nstan	ices	of ac	ccid	dent				$\perp$		$\perp$	$\perp$	L	<u>_</u>						$\perp$		$\perp$				$\perp$							Ш	$\perp$
						L																						(att	ach	ı se	par	ate	she	et if	nee	eded
Was the accident rela	ated to th	ne Ins	ured'	's occ	cupa	atio	n?			Yes	3		1	No	I	f so	o, h	ow'	?									$\perp$					$\perp$			
						$\perp$																														
Please describe the r	nature of	f Insur	red's	injur	ies:																															
Please list the names	and ad	dress	es of	all tr	reati	ng i	phys	sicia	ans	an	d h	osp	ital	s:														Τ			П		Т	Т		
						Ī									Ī																		I			
						I																						Τ					Τ			
Did police or other au	ıthorities	s inve	etinat	e the	acc	ride	nt?	Г	η.	Yes			_ N	No																						
•			•																																	
If yes, please provide	name, a	addre	ss an	nd tel	lepho	one	nu	mbe	er o	f al	l in	ves	tiga	ating	g of	ffice	ers	and	d ag	gen	cies	s: _	4	4	+	+	+	Ļ	Ļ	Щ	_	<u> </u>	$\perp$	Ļ	Щ	+
																														Ш			$\perp$		Ш	
Please list the names	and add	dress	es of	all tr	reatir	ng/	cons	sulti	ng	phy	/sic	ian	s o	r otl	her	he	alth	ncai	e p	orov	ride	rs:										$\perp$	$\perp$			
Name:						$\perp$																														
Street Address:																												Τ								
City:	$\exists \exists \exists$	1	Sta	te:	$\overline{\Box}$	Ŧ				Ť			Pir	nCo	de:						T	Ť	Ť	Ť	ī	F	ho	ne:		$\overline{\Box}$	T	Ŧ	Ŧ	T	П	$\overline{}$
If hospitalized, please	provide	e nam	ne and	d add	dres	s of	f hos	spita	al(s	) w	her	e tr	eat	me	nt v	vas	re	ceiv	/ed	: [	Ī		i	i	_	Т		Т	Ī	П	ī	T	Ť	Ī		T
				$\Box$		$\top$	Т				T	T			Т	T	Т						Ť	Ť	Ť	Ť	Ť	Ŧ	T	$\overline{\Box}$	Ŧ	$\overline{}$	Ŧ	Ħ	П	
Do you have any other	er insura	ance t	hat m	nay p	rovi	de /	cove	erag	je f	or t	his	acc	cide	ent o	or lo	oss	?	Ī		Yes	5	Ė	\   	lo.												
																_	_				_	_	_	_	_	_	_	_	_		_	_	_	_		
If yes, please identify	name, a	T	55, ai	iu po	JIICY	Tiu	IIIDE	#I OI	all	Oli	IEI	1115	ura	TICE	·	+	<u> </u>	<u> </u>				$\frac{1}{1}$	$\pm$	$\frac{1}{1}$	$\pm$	$\pm$	+	÷		$\Box$	井	$\pm$	$\pm$	$\perp$	Н	+
																												<u>_</u>		Ш				<u></u>	Ш	
AUTHORISATION I authorize any insurant information requested representatives, for the agree that a photograph I understand that any p misleading information	regarding purpose nic or facs person wh	g this e of ev simile of ho kno	claim valuati copy o	n and ling and of this	the land de sautle	loss eter hori h in	s repressivent rep	oorte ing on is to c	ed. cov s as lefra	l ur era vali	nde ge f id a or o	rsta for t	nd this	this clai igin	info m. I al. I	orm I kn agı	atio ow ree	on with at	vill l ave thi	be ι a ri s au	useo ght itho	d by to re	H ece	DF( eive n sh	a c all b	RG opy oe v	O of	Gene this I for	eral aut	I Ins thor dura	ura izat atio	nce, tion t n of t	or i upor this	its a n red clair	uthoques n.	orized st and
Date: DDMM	YYY	Υ																																		
		_																								Si	gne	ed (l	Insı	urec	d or	aut	hori	zec	ре	rson)
CERTIFICATION OF N	О ОТНЕ	RINS	URAI	NCE				h	ere	by o	cert	ify tl	hat	lha	ve r	no o	the	rac	cide	ent o	or h	ealt	h in	nsui	anc	ce o	ran	y otl	her	insı	ırar	ice c	ove	ring	this	loss.
Date: DDMM	YYY	Υ																								c:	and		Inc:			· aut	hor:	700		rean

## **HDFC ERGO General Insurance Company Limited**



### **HOSPITAL CASH PLAN - CLAIM FORM**

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

Form'C'

INSURED INFORMATION												
Name of Policy holder:												
Name of Employee/Member:												
(For group insurance policy only)												
Policy Number: Insured No./Certificate No. (If applicable):												
Name of Patient:												
Occupation: I.D. Card No.: Date	e of Birth: DD MM YYYY											
Relationship to the Policy holder: Self Spouse Child Staff/	Member Dependent											
1. Have you had any prior treatment for this or related conditions? Yes Yes												
Doctor's Name:												
Address:												
	Date: D D M M Y Y Y Y											
2. Are you making any other insurance claim as a result of this hospitalization/surgery?  Yes Yes												
Name of Insurance Company:												
Policy Number:												
3. (a) Was the hospitalization/surgery a result of an accident? Yes Yes												
(b) Date of accident: DD MM YYYY Time and place accident occurred:												
Please describe in detail the circumstances of accident:												
riease describe in detail the circumstances of accident.	(attach separate sheet if needed)											
	_ (andon separate sheet ii needda)											
4. Hospitalization												
Name of hospital:												
Date of admission: DDD MM VYYYY Date of Discharge: DDD MM VYYY	YYY											
I/We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in evmade, or in any further declaration the Company may require in respect of the said claim, shall make any false or fraud 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 organisation, institution or person, that has any records or knowledge of the patient and/or who has attended or may here information to HDFC ERGO General Insurance Company; (2) HDFC ERGO General Insurance Company or any of its appoint perform the necessary medical assessment and tests to evaluate the health status of the patient in relation to this claim. The successors and remains valid notwithstanding death or incapacity. Aphotocopy of this authorisation shall be as valid as the original contents of the patient in relation to the patient in relation to this claim.	after attend the patient to disclose such ted medical examiners or laboratories to his authorisation shall bind the patients											
Date:         D D M M Y Y Y Y           Place:	Signature of Patient											

## **HDFC ERGO General Insurance Company Limited**



**ACCIDENTAL INJURY - CLAIM FORM** 

Hospital Cash Claim (Accident or Sickness) Attending Physician's Statement

Form'D'

							INS	UREI	) INI	FOF	RMA	TIO	N																
Insured's Name:																		T		Т			$\overline{}$	$\overline{\top}$		$\overline{}$	$\overline{}$		_
Insured's Address:									$\overline{\Box}$		$\dot{\top}$			$\overline{}$		$\dot{\top}$	П	$\overline{}$	$\dot{\top}$	$\dot{\top}$		$\Box$	十	$\mp$	$\overline{\Box}$	十	$\pm$	$\exists$	=
			T				1		$\overline{1}$	T	Ť			Ť		Ť	П	T	Ť	Ť	T	П	Ť	Ť	Ħ	寸	Ŧ	П	=
Date of Birth:	D D N	и м	YY	YY		Marit	al St	atus:			Mar	ried			Un	mar	ried												
Phone No. (Off):									Ph	one	No.	(Re	s):																
Name and																								$\perp$					
address of employer:																										$\Box$			
Policy Number:								Ins	sure	ďs (	Оссі	ıpat	ion:										$\perp$	$\perp$		$\Box$			_
							CLA	AIM IN	NFO	RM	ATIC	N																	
Date of accident:	D M M	YY	YY										rst t	reati	nent:	D	D	M	M		YY	′ Y	Υ						
Please describe in det	tail the nat	ure of th	ne Insu	ured's	injuri	es:										T							$\top$		П				_
																			Ť			$\Box$	Ť	Ī		T			Ξ
Was the accident relat	ted to the I	nsured'	s occu	pation	1?		Yes		N	0	If s	o, ho	ow?			T			T	T			T	T	П	T	$\top$	$\overline{\Box}$	_
						T			_							T	П	Ť	Ť	Ť	T	П	Ť	Ť	$\overline{\Box}$	寸	$\overline{}$	$\overline{\Box}$	=
Was the Insured hosp	italized?	Y	'es	N	lo																								
If yes, please list the n	names and	addres	ses of	all ho	spital	s and	l all a	admis	sion	/dis	cha	ge (	date	s:									$\Box$	$\perp$		$\Box$			_
																						Ш	$\perp$	$\perp$		$\perp$	$\perp$		_
Did the Insured have a	any injury d	or illnes	s prior	to the	acci	dent t	hat o	contri	bute	d to	the	acc	iden	nt or	to the	e Ins	sure	ďs	pre	sen	t co	nditi	ion?	?		Ye	s		N
If yes, please describe	<b>∌</b> : ☐																					Ш	$\perp$	$\perp$		$\perp$			_
																						Ш				$\perp$	$\perp$		_
Were any surgical pro	cedures pe	erforme	d?	Ye	s	\	10																						
If yes, please list all pr	rocedures,	and da	tes pe	rforme	ed:											Ļ	Щ			Ļ		Щ		Ļ	Щ		<u>_</u>	Ш	_
					Щ				Ш	_	<u> </u>	Щ		<u> </u>	Щ	<u> </u>	Щ	_	<u> </u>	<u> </u>		Щ	<u></u>	<u></u>	Щ	ᆜ	<u></u>	Щ	_
What are the Insured's	s current si	ubjectiv	e sym	ptoms	? _					_	<u> </u>	Ш				<u> </u>	Ш	_	4	<u> </u>		Щ	4	<u></u>	Щ	ᆜ	<u></u>	Щ	_
												Ш		_		_		_	+	<u> </u>	_	Щ	ᆣ	ㅗ	Щ	ᆜ	<del>_</del>	Щ	_
What are the objective	findings?	(please	inclu	de res	ults o	f curr	ent >	(-rays	, lab	test	s, e	tc.)?	, [	_		+		_	+	+	_	Щ	+	+	$\perp \perp$	ᆣ	+	Щ	=
												Ш										Ш			$\perp \perp \perp$			Ш	_
Dates of total disability				M M	Y	Y   Y	Y		D		M		Y	Y \															
Dates of partial disabil	-			M M		YY	_	10:	D	D	M	M	Υ	Y	Y														
Date Insured able to re				M M	Y		Υ	٦																					
Was the Insured seen					Ш	Yes		No											_	_	_								
If yes, please list the n	names and	addres	ses of	all oth	ner ph	nysici	ans:	Щ		_	+			+		+	Ш	_	+	+	_	Щ	井	$\pm$	$\coprod$	井	$\pm$	Щ	=
									Ш			Ш					Ш					Ш			Ш	_		Ш	_
					Αī	TEN	DIN	G PH	YSIC	CIAN	IN I	FOF	RMA	TIO	N														
Name of Attending Ph	ysician:																												_
Insured's Address:											$\perp$									Ţ			$\perp$	$\perp$	Щ	$\perp$			_
																	Pho	ne	No.	:		Ш		$\perp$		$\perp$	$\perp$		_
I understand that any pe		_							eive a	any i	nsu	ranc	е со	mpa	ny file	es a	clain	n co	ntai	ining	g an	y ma	ateri	ally	false	, inc	comp	olete	0
misleading information n	nay be subj	ect to pro	osecuti	ion for i	nsura	ince fr	aud.																						_
Date: DDMMY	/ Y Y Y																												
																				,	SIGI	NEC	) (Δ	tton	dina	Ph	vsici	ian)	_

## **HDFC ERGO General Insurance Company Limited**



### **ACCIDENTAL INJURY - CLAIM FORM**

Accidental Death Claimant's Statement

Form'E'

	INSURED INFORMATION	
Insured's Name:		
Insured's Address:		
Date of Birth:	D D M M Y Y Y Y M Marital Status: Married Unmarried	
Phone No. (Off):	Phone No.(Res):	
Name and address of last employer:		<u></u>
Policy Number:	Insured's Occupation(at time of death):	
Did the Insured have a	any other accident or life insurance? Yes No	
If yes, please list all co	ompanies, policy numbers and insurance amounts:	$\perp$
		$\perp$
	CLAIM INFORMATION	
Date of accident:	D D M M Y Y Y Y Time and place accident occurred:	
Please describe in deta	ail the circumstances of accident:	
	(attach separate sheet if nee	ded)
Was the accident relate	red to the Insured's occupation?  Yes  No If so, how?	
Please describe the ca	ause of the Insured's death:	
Please list the names a	and addresses of all treating physicians and hospitals:	$\Box$
		$\perp$
		$\perp$
Did police or other auth	horities investigate the accident? Yes No	
If yes, please provide r	name, address and telephone number of all investigating officers and agencies:	$\perp$
Was an autopsy perfor	rmed? Yes No If yes, please provide name and address of Medical Examiner:	$\perp$
		$\perp$
Was a coroner's inque	est held? Yes No If yes, what was the determination?	Ļ
	CLAIMANT INFORMATION	
Claimant's Name:		
Age: Yrs	Relationship to Insured:	
Claimant's Address:		$\perp$
Phone No. (Off):	Phone No.(Res):	
In what capacity are yo	ou making this claim? Beneficiary Executor* Administrator* Guardian* Trustee* Assign	nee*
insurance company, phy regarding the insured to General Insurance, or its authorization upon reque the duration of this claim	fied copy of all documents supporting your authority (e.g., Succession Certificate, Notarised Affidavit, Notarised will, etc.) I authorize visician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowled by release any information requested regarding this claim and the loss reported. I understand this information will be used by HDFC Effectives and the propose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of est 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 in. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing ete or misleading information may be subject to prosecution for insurance fraud.	edge RGC f this id for
Date: DD MM	Y Y Y Y  SIGNED(Claimant or authorized person	

## **HDFC ERGO General Insurance Company Limited**



## **Consent for Mode of Claim Payment**

Name of Insured		
Policy Number		
Claim Number		
Beneficiary Name		
Mode of Payment (Please tick for mode of pa	Cheque Fund Transfer yment)	
	(All Fields are Mandatory in case of Fund Transfer)	
Insured's Name a Bank Account	s per	
Bank Account Nu	mber	
Branch Name		
IFSC Code	Email address	
Attachments In Support of Bank Del (Please tick the type of	ails Cancelled Cheque Bank Passbook Copy proof submitted)	
against the particular	claim number mentioned above.	
Signature of Stamp Required in		Date: DD MM YYYY