TATA-AIG GENERAL INSURANCE COMPANY LTD

A-501,5Th Floor, Bldg No -4,
Infinity Park, Dindoshi,
Malad East – Mumbai – 400 097

GROUP PERSONAL ACCIDENT CLAIM FORM

IMPORTANT

1. **Issuance of this form is not an admission of Liability or a waiver of the terms, conditions and exceptions of the insurance contract.**
2. **No claim will be admitted without a Medical Report as per format to be obtained at claimant's expense.**
3. **We may call for additional information/ documents as relevant.**

Policy No. ---------- **Claim No. ----------**

1. **COMPANY DETAILS:**
   Name of the Organization _____
   Address _____
   _____**State**_____ **Pin**_____

   Contact Persons Name _____**Phone No**_____
   Fax No. _____**E-Mail Id** _____

2. **INSURED PERSONS DETAILS**
   NAME _____
   Address _____
   _____STATE _____ PIN _____
   Phone No. _____ Fax No. _____E - Mail id. _____
   Age _____ SEX _____

3. **DETAILS OF ACCIDENT**
   Time and Date _____
   Place and Location (Full Address)- _____
   Please describe in detail how the incident took place_____
   Please describe details of injury sustained _____
   Specify the injured parts of body _____

4. **WITNESSES**
   1) Name _____ 2) Name _____
   Address _____ Address _____
   _____ _____
   _____ _____

5. **TREATMENT DETAILS**

- Treating Doctor
  Name _____
  Address _____
  Phone _____
  Registration No ----------

- Family Doctor
  Name ----------
  Address ----------
  Phone ----------
  Registration No. ----------

- Hospital(s) if hospitalised
  Name ----------
  Address ----------
  Phone No ----------

6. **AMOUNT OF CLAIM** (Subject to Policy coverage)
   A Total Temporary Disablement Amount (Rs.)_____ (Rs. _____ per week for_____weeks____days)

   B Medical Expenses Amount (Rs.)_____

   C Accident Death Amount (Rs.)_____

   D Permanent/Partial Disability Amount (Rs.)_____

7. **PAST HISTORY**
   A Have you made any claims in the PAST? YES/NO

   B If YES, please give the following details:

Sr. No	Name of Insurance Co.	Policy No.	Accident Details	Amount
1.				
2.				

1. **Have the Police Authorities been informed of this accident?** YES/ NO If Yes, FIR/ Case Diary No.----------

Employment details:
Designation/ Grade/ Occupation: _____ Nature of Duty_____ Date of joining_____

8. **LEAVE PARTICULARS**
   The Employee was on leave from_____ to _____.

   No. of days _____

9. **SALARY DETAILS**
   Month & Year _____
   Basic Pay _____
   Dearness Allowance _____
   Other Allowance _____
   Gross Salary _____

10. **Please put a [√] mark against the documents being sent:**

Attending Doctor's Report [ ],Disability from the Doctor [ ], Fitness Certificate from the Doctor [ ], X-ray Films [ ], X-ray reports [ ],

Original Admission/discharge card [ ],Original Medical Bills / receipts [ ], Employers Leave Certificate [ ], Latest Salary Certificate [ ].

I hereby declare that I have suffered injuries as described above and all the details given are ABSOLUTELY **TRUE AND CORRECT**.I hereby agree to forfeit all my rights to compensation if any of the foregoing facts and /or details are found to be false or incorrect, further authorise the hospital ,doctor diagnostic laboratory,organisation,establishment or any other body or person dealt with in the course of this claim to give any information or document sought for by the Insurance Company.

Signature of Insured Person/ Claimant

Signature of Authorized Person
Company Seal

Date:
Place:

ATTENDING PHYSICIAN'S STATEMENT

PLEASE ANSWER ALL QUESTIONS

1 Name of Injured Person: ----------
Age ----------
2 Address ----------

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3 Nature of the Accident and Details of Injuries Sustained ----------
(Specify the part of the body) ----------

4 Does the Cause of Accident as stated by the Claimant tally with the Injuries noticed by you? ----------

5 Are the injuries solely due to the accident or traceable to any previous injuries/ disease/ infirmities? ----------
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6 Was the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition. ----------

7 Was the Claimant hospitalized? If so for what period? ----------

8 What treatment was given and Operations performed? ----------

9 Give dates of treatment: Home: From---------- ---- To ----------
Clinic/Hospital :From----------To----------

10 Was he under the influence of intoxicants or drugs at the time of accident?----------
(If yes, what action taken?)

11 Are you his usual medical Attendant? YES / NO
If you have treated him for any previous illness or injury, Please give details: ----------
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12 Have other Doctors been in Attendance or Consultation? If yes, Please give details. ----------
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13 Has this accident been reported to the Police Authorities? If yes, Case No: ---------- Police Station ----------

14 Is this claimant Totally Disabled from each and every occupation? ----------

15(a) How long was or will the claimant be totally disabled from current occupation? From----- ---------- To----------
(b) Estimated date of return to Work. ----------

16 What is the Prognosis? ---------- ----------

This information is true to the best of my knowledge.

Doctor's Signature **Date:** **Regn No:**

Doctors Name:
Address and Phone No.