

GROUP PERSONAL ACCIDENT CLAIM FORM

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Signed (Insured or authorized person)

ACCIDENTAL INJURY - CLAIM FORM

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	Date: DD MM	YY	YY]																									Si	gn	ed (Ins	ure	d o	r au	ıtho	rize	ed p	ers	on)
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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.: Da	te 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	
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?	
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 YYYYY Time and place accident occurred:	
Please describe in detail the circumstances of accident:	
	(attach separate sheet if needed)
4. Hospitalization	
Name of hospital:	
Date of admission: DD MMM YYYYY Date of Discharge: DD MMM YYY	YY
I/We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in emade, or in any further declaration the Company may require in respect of the said claim, shall make any false or frauc 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 compar 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. Successors and remains valid notwithstanding death or incapacity. A photocopy of this authorisation shall be as valid as the original contents of the patient in relation to this claim.	eafter attend the patient to disclose such nted medical examiners or laboratories to This authorisation shall bind the patients
I/We hereby understand, declare, consent and authorise the Company that personal health details, medical history and Company may be utilised for processing the claim made under the Policy. I/We hereby also understand, declare and consent t and disseminate the same to any service provider for providing services related to insurance.	
Date: DDMMNYYYY	
Place:	Signature of Patient



ACCIDENTAL INJURY - CLAIM FORM

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

Form'D'

Attending r nyst	oran o oran		•			IN	ISUR	RED	INF	OR	MA	TIO	N																	
Insured's Name:														T		T				7					\neg	\top		\top	T	
Insured's Address:				+			+			\pm	\pm			$\overline{}$	\pm	$\dot{\top}$	$\dot{\top}$		\dashv	\pm	\pm		\exists	一	\mp	\pm	\exists	\mp	\pm	\exists
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Date of Birth:	D D M N	1 Y Y	YY		Ma	arital	Statu	JS:		_ N	Лагі	ied		Ī	<u> </u>	Unr	narı	ried												
Phone No. (Off):									Pho	ne	No.	(Re	s):			Τ														
Name and												Ì		T									$\overline{\Box}$	$\overline{\Box}$	Т	\top	\Box	\top	T	
address of employer:																									Ī	Ī			Ī	
Policy Number:								Insi	ured	's C	Оссі	ıpat	ion:												\perp					
						С	LAIN	I IN	FOR	MA	ATIC	N																		
Date of accident:	M M Y	YYY								D	ate	of fi	irst	trea	ıtme	ent:	D	D	N	M		YY	/ Y	Y]					
Please describe in det		of the In	_ isured's	iniu	ries:	[_						T		Ī	Ť		Ť			T	\top	П	\top		
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Was the accident relat	ted to the Insu	ıred's oc	cupation	า?		Ye	s		No		If so	o, he	ow?	, [Ť	Ť	T		Ť	Ť	Ť	T	$\overline{\Box}$	$\overline{\Box}$	Ŧ	Ŧ	$\overline{\Box}$	Ŧ	Ŧ	$\overline{\Box}$
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Was the Insured hospi	italized?	Yes		No.								-																		
If yes, please list the n		 dresses	of all ho	spit	als a	nd a	ll adr	niss	sion/	disc	chai	ge	date	es:															I	
Did the Insured have a	any injury or il	lness pri	or to the	ac	cider	nt tha	t cor	ntrib	uted	to	the	acc	ide	nt o	r to	the	Ins	ure	d's	pre	sen	t cc	ndi	tion	ı?		Ye	es		No
If yes, please describe	e:																													
Were any surgical prod	cedures perfo	rmed?	Ye	es		No																								
If yes, please list all pr	e any surgical procedures performed? Yes No s, please list all procedures, and dates performed:																				\Box									
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What are the Insured's	s current subje	ective sy	mptoms	?																				\square	\Box	\perp		\perp	I	
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What are the objective	e findings? (ple	ease inc	lude res	ults	of c	urren	ıt x-ra	ays,	labt	ests	s, e	tc.)?	? [\Box	\perp	\perp		\perp	\perp	
																									\perp	\perp		\perp	\perp	
Dates of total disability	: From:	D D	M M	Υ	Υ	Y] .	To:	D [)	М	М	Υ	Υ	Υ	Υ														
Dates of partial disabil	lity: From:	D D	M M	Υ	Υ	YY] .	To:	D [М	М	Υ	Υ	Υ	Υ														
Date Insured able to re	eturn to work:	D D	M M	Υ	Υ	Y																								
Was the Insured seen	by any other	physicia	n?		Ye	s		No																						
If yes, please list the n	names and ad	dresses	of all otl	her	phys	ician	s:																		\perp			\perp	I	
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Name of Attending Phy	ysician:																								I	I			I	
Insured's Address:																									\perp			\Box	\top	
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I understand that any pe	erson who know	wingly an	d with in	tent	to de	fraud	l or de	ecei	ve a	ny ir	nsuı	anc	e co	omp	any	file	sac	clair	n cc	nta	ining	g an	ıy m	ate	rially	/ fals	se, ir	icom	ıplet	e or
misleading information n	nay be subject	to prosec	ution for	insu	ranc	e frau	ıd.																							
I/We hereby understand	d, declare, con	sent and	l authoris	se th	ne Co	ompa	iny th	nat p	erso	nal	hea	alth	deta	ails,	me	dica	ıl his	stor	y ar	ıd fi	nan	cial	info	orm;	atior	า, as	s pro	vide	d to	the
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and disseminate the sam	ne to any servic	e provide	er ior prov	viain	y ser	vices	relat	ea t	UINSI	urar	ice.																			
Date: DDMMY	- Y Y Y																													
Date.	any person who knowingly and with intent to defraud or deceive any insurance company files a claim coation may be subject to prosecution for insurance fraud. erstand, declare, consent and authorise the Company that personal health details, medical history an utilised for processing the claim made under the Policy. I/We hereby also understand, declare and conserve same to any service provider for providing services related to insurance.															SIC	NE	— ار ا	Δtte	ndin	ıa Ph	nvei,	rian							



ACCIDENTAL INJURY - CLAIM FORM

Accidental Death

Form'E'

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Insured's Name:																											
Insured's Address:																											
																											\perp
Date of Birth:	D D M	M Y Y	YY		Mari	tal S	Status	s: [M	arrie	ed			Unn	narri	ied											
Phone No. (Off):								Ph	one	No.	(Re	s):															
Name and address																											
of last employer:																											
Policy Number:					Ins	sure	ed's O	ccup	atio	n(at	time	of	deat	h):													\perp
Did the Insured have a	any other acc	cident or I	ife insura	ance?		Ye	s [10																		
If yes, please list all co	ompanies, po	licy numb	pers and	insura	ance a	amo	unts:	L	_	Ш	_	+	Щ	+			4	+	<u> </u>		_	+		<u> </u>		_	¥
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Date of accident:	D D M M	1 Y Y	YY	Time	e and	pla	ce ac	ciden	t oc	curr	ed:																I
Please describe in det	ail the circum	nstances	of accide	ent:								T					T	T	T		T	T		T		T	T
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Was the accident relat	ed to the Ins	ured's oc	cupation	?	Ye	es		No	II	so,	hov	ı?		$\overline{}$			$\overline{}$	_	T			Ť					Т
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Please describe the ca	ause of the Ir	nsured's o	death:						İ			İ		İ			İ		İ			İ		İ			İ
Please list the names	and address	es of all t	reating p	hysici	ans a	nd h	nospi	als:	Г			T		T			Ī					T				T	T
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Did police or other aut	horities inves	stigate the	e accide	nt?	Ye	es		No																			
olid police or other authorities investigate the accident? Yes No yes, please provide name, address and telephone number of all investigating officers and agencies:															Т												
7.1, 7.1.1																\pm	$^{+}$				$\overline{}$					Ť	
Was an autopsy perfo	rmed?	Yes	No	If v	es, pl	leas	e pro	vide	nam	e ar	nd a	ddre	ess c	of Me	edic	al E	xar	nine	r:	Н	\pm	\pm		+		\pm	T
]		,															T	П		+		+		+	T
Was a coroner's inque	est held?	Yes	No		li li	f ves	s, wh	at wa	s the	e de	term	inat	tion	? [$\overline{}$	\pm	$^{\perp}$		\pm	\pm		+			÷
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Claimant's Name:						Щ		<u> </u>		Щ			Щ		Щ	Щ											
Age: Yrs	Relati	ionship to	Insured	l:		\perp			Щ	\perp		\perp		Щ	\perp	\perp											_
Claimant's Address:						$\frac{\square}{\square}$			+		+	+		+	<u> </u>		+	+	<u> </u>		<u> </u>	+		<u> </u>		+	Ļ
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Phone No. (Off):								Pho	ne N	lo.(F	Res)	: L		Ш						_					,		
In what capacity are ye	ou making th	is claim?	Be	neficia	ary		Exe	cutor	.*		Adn	ninis	strate	or*	L		Gua	rdia	n*		Tr	uste	e*		As	sigr	ee
*Please provide a certifinsurance company, phyregarding the insured to General Insurance, or its authorization upon requesthe duration of this clair materially false, incompl I/We hereby understand Company may be utilise and disseminate the san	visician, hospit o release any s authorized re est and agree m. I understar ete or mislead d, declare, col d for processir	al or other information epresentate that a phound that an ling informations musent and ing the claim	r healthca on reques tives, for to tographic by person nation may d authoris m made u	are prosted re he pur c or fac who k y be su se the	vider, gardin pose o simile cnowin bject t Comp	or any the cope of	ny oth nis cla valuati y of th and v osecu that	ner orgim and and and and and and and and and and	ganized the decire the decire the decire the decire the decired th	zatio e los term zatio to d surar nealt	n, in ss re iining n is a efrai nce f h de	stitu porte g cov as va ud o raud	ition ed. I veraç alid a or de d. s, me	or pe und ge fo is the ceive	erso erst r this e orig e an	n tha and s cla gina y ins	at m this im. I. I a sura	ay h info I kno gree ance	orma ow I e tha cor	rec ation have t this npa	ords will e a ri s au ny fi	be ught to thorizing the angles and the angles and the angles and the angles and the angles and the angles and the angles and the angles and the angles and the angles and the angles and the angles and the angles and the angles and the angles angles and the angles angles and the angles angles and the angles angles and the angles angles and the angles a	cume used o rec zation a clain	nts of by Feive shape of shape	or kn IDF(a cop all be ontain	owle C EF by o vali ning	edg RG f th d fo ar
Date: DD M M	Y Y Y Y		7															ON!!		01-:			auth				_



Consent for Mode of Claim Payment

Stamp Required in case of Company

Name of bosons d														 							
Name of Insured																Ш					
Policy Number																					
Claim Number																					
Beneficiary Name																					
Mode of Payment (Please tick for mode of page)	ayment)	Che	eque			Fund	d Trar	nsfer													
				(All Fiel	ds are	Manda	itory in	case o	f Fund	Transf	fer)									
Insured's Name a Bank Account	as per																				
Bank Account Nu	umber																				
Branch Name																					
IFSC Code								Ema	il add	ress											
Attachments In Support of Bank De (Please tick the type o	etails of proof submi	itted)	Cano	celled	Chec	que		Ва	ank P	assbo	ok C	ору									
Signature of	f Beneficia	ry												I	Date:		D D	M	Л	Y	YY