Bajaj Allianz General Insurance Company Limited

Regd. Office: Bombay Pune Road, Akrudi, Pune 411 035 & Head Office: GESCO Plaza, Airport Road, Yerawada, Pune 411 006

PERSONAL ACCIDENT INSURANCE

CLAIM FORM

Policy No		Claim No.	
		Date of registration	
Regional/Branch Office Code			
Broker/Agent		Code	

1. Name of the Insured 2. Customer ID					
3. Address of the Insured	Plot No/Door No.		Building name		
	Road				
	Area				
	City		Pin code		
	State				
	Phone No.				
	E-mail Id				
10. Profession or Occupation					

Policy details			
Sum Insured		Table of Cover	

5. a)Name of the insured person died/ injured in the accident b) Relationship with the employee/ member c) Employee/member identification no.	Self/Spouse/Children
6. a) Date of the Accident b) Time of the Accident c) Where it happened? d) Name & Address of the Witness	
7. How did the Accident occur?	
8. Nature of Injury received (if to limb or Eye state whether right or left)	

9. a) Nature of disablement b) Extent of disablement c) Period of temporary total disablement d) Present state of incapacity	(From……to…..……)
10. Name and address of Surgeon in attendance	
11. Where and when can a Medical Officer of our Company visit you, if necessary?	
12. a) Are you insured in any other Office or Offices granting compensation for accident? b) If so state name and address of company or Companies and amount of Insurance	

I/We hereby declare that the foregoing statements are true in all respects and that I/We have not attempted to conceal from the company anything with which it ought to be made acquainted and also that if I/We have made or in any further declaration the Company may require shall make any false or fraudulent statement or any suppression, concealment or untrue averment whatever, the Policy shall be void and my/our right to compensation forfeited and am/are willing if required, to make a statutory Declaration before a Justice of the Peace of the truth of the whole of the foregoing statement or any other statement I/We may make in connection with this claim. I consent and authorise the insurers to seek medical information from any Hospital/Medical Practitioner who has at any time attended concerning the claim.

Witness: Name……
Signature ……

Signature of the Insured
Date ……..
Address …… Date
……..

MEDICAL CERTIFICATE

(Claim must be supported by the Medical Evidence furnished by the Insured at his/her expense)

Name of Claimant Age

1. a) Nature and cause of Accident

   b) Details of injury, diagnosis & treatment

   b) If to eye or limb, state left or right

   c) Whether the appearance of the injuries are consistent with the account given of the accident

2. Date on which you first attended claimant for this injury

3. Has claimant been totally prevented from attending to any portion of his business? If so for how long?

4. Is claimant suffering from any disease or illness apart from his injury and is there any illness by circumstances which may tend to retard recovery? If so, give particulars

5. Present condition

6. How long from the happening of the Accident do you consider

   a) Total disablement will last
   b) Partial disablement will last

7. Date from which the patient is fit to resume the duties

Having personally examined the above named Insured, I certify that the above statements are correct and that the injured person is necessarily disabled by the accident referred to.

Signature: Doctor's Stamp

Name:

Qualification: Date:

Address: