

Personal Accident Claim Form

Claim Form



WITH YOU ALWAYS

Tata AIG General Insurance Company Limited: A-501, 5th Floor, Building No.4, Infinity Park, Gen. A.K. Vaidya Marg, Dindoshi, Malad (East), Mumbai 400 097

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.

Claim No. _____

Policy No. _____

1. PERSONAL DETAILS

Name (In block letters)

a) Insured

First Name	Middle Name	Surname

b) Claimant

First Name	Middle Name	Surname

Address

--

City

--

State

--

 PIN

--

Phone (O)

--

 (R)

--

Fax

--

 Mobile

--

E-mail

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Age

	yrs.		Occupation <table border="1" style="width:100%; border-collapse: collapse;"><tr><td style="height: 15px;"></td></tr></table>	

2. ACCIDENT DETAILS

Time and Date

D	D	M	M	Y	Y	Y	Y						

Place and Location (full address)

Cause Description

3. DETAILS OF INJURIES

Specify injured parts of body

Total disablement (if any)

	Percentage	<table border="1" style="width:100%; border-collapse: collapse;"><tr><td style="height: 15px;"></td></tr></table> %		(In words)

4. WITNESSES

1) Name

--

Address

--

City

--

State

--

 PIN

--

Phone

--

 Mobile

--

2) Name

--

Address

--

City

--

State

--

 PIN

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Phone

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 Mobile

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5. TREATMENT DETAILS

A. Name of Casualty Doctor

Address

Phone

Registration No.

B. Name of Family Doctor

Address

Phone

Registration No.

C. Name of Hospital

Address

Phone

6. CONTACT DETAILS

Address where available

Phone

(Please be available at this place where our representative may call on you)

7. CONFINEMENT

A. Total Confinement

From _____ To _____

(This should be the actual days when fully confined to bed on Medical Advice)

B. Partial Confinement

From _____ To _____

(This should be the days when partially confined to bed)

8. AMOUNT OF CLAIM

A. Total Temporary Disablement Amount (Rs) _____

B. Permanent Disablement Amount (Rs) _____

C. Medical Expenses Amount (Rs) _____

D. Death Amount (Rs) _____

9. PAST HISTORY

A. Have you made any claims in the PAST? YES NO

B. If YES, please give details including accident and Insurance details _____

10. Are you insured under any other policy? YES NO

If YES, please give full details _____

11. Have the Police Authorities been informed of this accident? YES NO

If YES, Case No. _____ Police Station _____

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. I 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.

Date: _____

Place: _____

Signature of the Insured

ATTENDING PHYSICIAN'S STATEMENT

PLEASE ANSWER ALL QUESTIONS

1. Name of Injured Person:

2. Age

3. Address

 Phone

4. Nature of the Accident and Details of Injuries Sustained _____

5. Does the Cause of Accident as stated by the Claimant tally with the Injuries noticed by you? _____

6. Are the injuries solely due to the accident or traceable to any previous injuries/ disease/ infirmities? _____

7. Was the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition.

8. Was the Claimant hospitalized? If so for what period? _____

9. What treatment was given and Operations performed? _____

10. Give all dates of treatment : Clinic/Hospital: From _____ To _____
Home : From _____ To _____

11. Was he under the influence of intoxicants or drugs at the time of accident? _____

12. Are you his usual medical Attendant? _____

If you have treated him for any previous illness or injury, please give details. _____

13. Have other Doctors been in Attendance or Consultation? _____

If yes, Please give details _____

14. Has this accident been reported to the Police Authorities? If yes, Case No: _____ Police Station _____

15. Is this claimant Totally Disabled from each and every occupation? _____

16. (a) How long was or will the claimant be totally disabled from current occupation?

From _____ To _____

(b)How long was or will the claimant be partially disabled from current occupation?

From _____ To _____

(c) Estimated date of return to Work. _____

17. What is the Prognosis? _____

Doctor's Signature Date: _____ Regn No: _____

Doctors Name

Address and Phone No.

 Phone

Tata AIG General Insurance Company Limited

Registered office: Peninsula Business Park, Tower A, 15th Floor, G. K. Marg, Lower Parel, Mumbai - 400 013.

For more information; Email us at customersupport@tataaig.com or visit www.tataaig.com
Contact us on our 24 hour Toll Free Helpline at 1800 266 7780 or 1800 22 9966 (only for senior citizen policy holders)

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Insurance is the subject matter of the solicitation