Personal Accident Claim Form

Claim Form



A&H Claims Department, Tata AIG General Insurance Co. Ltd., 7th and 8th Floor, Romell Tech Park, Cama Industrial Estate, Western Express Highway, Goregaon(E), Mumbai, Maharashtra 400063

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 DETA	ILS				
Name (In block letters)					
a) Insured					
h) Claimant		First Name		Middle Name	Surname
b) Claimant		First Name		Middle Name	Surname
Address					
	City				
	State			PIN	
	Phone (O)			(R)	
	Fax			Mobile	
	E-mail				
	Age	yrs.		Occupation	
	1.80	yı s.		Occupation	
2. ACCIDENT DETAI	LS				
Time and Date		D D M M Y Y	/ Y Y		
Place and Location					
(full address)					
Cause Description					
3. DETAILS OF INJU	RIES				
Specify injured					
parts of body					
Tatal disablement					
Total disablement (if any	Deveete	- 0/			
	Percentag	e %		(In wo	rds)
4. WITNESSES					
1) Name					
Address					
	City				
	State			PIN	
	Phone			Mobile	
2) Name					
Address					
	City				
	State			PIN	
	Phone			Mobile	

5. TREATMENT DETAILS

Α	Name of Casualty Doctor																				
	Address																				
	Phone										Re	gistra	ation	No.							
B.	Name of Family Doctor																				
	Address																				
	Phone										Re	gistra	ation	No.							
C.	Name ofHospital																				
	Address																				
	Phone																				
NTAC	T DETAILS																				
	lress where available																				
Pho NFIN	ement	(Please	e be a	avail	able	at this	s plac	ce wh	nere o	our rej	oresei	ntativ	ve ma	ay ca	all on	you)					
NFIN A. To	EMENT otal Confinement	From . (This s	houlc	d be	the a	actual	days	whe	- To en full	y con	fined	to be	ed on	Me	dical	-	e)				
NFIN A. To	EMENT	From .	hould	d be	the a	actual	days	s whe	- To en full - To	y con	fined	to be	ed on	Me	dical	-	e)				
NFIN A. To B. F	EMENT otal Confinement	From (This s	hould	d be	the a	actual	days	s whe	- To en full - To	y con	fined	to be	ed on	Me	dical	-	e)				
NFIN A. To B. F	EMENT otal Confinement Partial Confinement	From . (This s From . (This s	hould	d be	the a	actual	days	s whe	- To en full - To	y con	fined	to be	ed on	Me	dical	-	e)				
NFIN A. To B. F IOUN A.	EMENT Total Confinement Partial Confinement	From . (This s From . (This s	hould	d be d be A	the a	actual days v	days vhen	s whe	- To en full - To	y con	fined	to be	ed on	Me	dical	-	e)				
NFIN A. To B. F OUN A. B.	EMENT Total Confinement Partial Confinement Total Temporary Disablement	From . (This s From . (This s	hould	d be d be A A	the a the o moui moui	actual days v nt (Rs)	days vhen)	s whe	- To en full - To	y con	fined	to be	ed on	Me	dical	-	e)				
NFIN A. To B. F OUN A. B. C.	EMENT Total Confinement Partial Confinement TOF CLAIM Total Temporary Disablement Permanent Disablement Medical Expenses	From . (This s From . (This s	hould	d be d be A A A	the a the o	actual days v nt (Rs) nt (Rs)	days vhen))	s whe	- To en full - To	y con	fined	to be	ed on	Me	dical	-	e)				
NFIN A. To B. F OUN A. B. C. D.	EMENT otal Confinement Partial Confinement IT OF CLAIM Total Temporary Disablement Permanent Disablement Medical Expenses	From . (This s From . (This s	hould	d be d be A A A	the a the o	actual days v nt (Rs) nt (Rs) nt (Rs)	days vhen))	s whe	- To en full - To	y con	fined	to be	ed on	Me	dical	-	e)				
NFIN A. To B. F OUN A. B. C. D. ST HIS	EMENT otal Confinement Partial Confinement TOF CLAIM Total Temporary Disablement Permanent Disablement Medical Expenses Death	From . (This s From . (This s ent	hould	d be A A A A	the a the o	actual days v nt (Rs) nt (Rs) nt (Rs)	days vhen))	s whe	- To en full - To	y con	fined	to be	ed on	Me	dical	-					
NFIN A. To B. F OUN A. B. C. D. ST HIS A.	EMENT otal Confinement Partial Confinement TOF CLAIM Total Temporary Disablement Permanent Disablement Medical Expenses Death STORY	From . (This s From . (This s ent	hould hould	d be d be A A A A	the a the o moun moun	actual days v nt (Rs) nt (Rs) nt (Rs)	days vhen) -) -	parti	- To en full - To ially c	y con	fined	to be	ed on	Me	dical	Advic					
NFIN A. To B. F OUN A. B. C. D. ST HIS A. B.	EMENT otal Confinement Partial Confinement TOF CLAIM Total Temporary Disablement Permanent Disablement Medical Expenses Death STORY Have you made any claims	From . (This s From . (This s ent s in the P ncluding	hould hould AST ? accid	d be d be A A A A	the a the o moun moun	actual days v nt (Rs) nt (Rs) nt (Rs)	days vhen) -) -	parti	- To en full - To ially c	y con	fined	to be	ed on	ſES	dical	Advic					
NFIN A. To B. F OUN A. B. C. D. ST HIS A. B. 10.	EMENT Total Confinement Partial Confinement TOF CLAIM Total Temporary Disablement Permanent Disablement Medical Expenses Death STORY Have you made any claims If YES, please give details in	From (This s From (This s (This s ent	hould hould AST ? accid	d be d be A A A A A	the a the o moun moun moun	actual days v nt (Rs) nt (Rs) nt (Rs)	days vhen) _) _) _	parti	- To en full - To ially c	onfin	fined	to be	ed on	ſES	dical	Advic					
NFIN A. To B. F OUN A. B. C. D. ST HIS A. B. 10.	EMENT otal Confinement Partial Confinement TOF CLAIM Total Temporary Disablement Permanent Disablement Medical Expenses Death STORY Have you made any claims If YES, please give details in Are you insured under any	From (This s From (This s (This s ent s in the P ncluding other po ils	AST ? accid	d be A A A A Ient	the a moun moun moun and	actual days v nt (Rs) nt (Rs) nt (Rs)	days vhen)) -) -) -	parti	- To en full - To ially c	onfin	fined	to be	ed on	ſES	dical	Advic					

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

PLI	EASE ANSWER ALL QUESTI	ONS	_																					
1.	Name of Injured Person:																							
2.	Age																							
3.	Address																							
															Phc	one								
4.	Nature of the Accident and D	etails of	Injuries	Susta	ined _																		 	
5.	Does the Cause of Accident a	s stated	by the (Claima	nt tall	ly wit	h the	e Inji	uries	notio	ed b	у уо	ou? _										 	
6.	Are the injuries solely due to	the accie	dent or t	tracea	ble to	any	prev	/ious	inju	ries/	dise	ase/	infir	mitie	s?								 	
7.	Was the injured person suffer condition.	ring fron	n any di	sease	or inji	ury w	/hich	may	/ hav	ve cor	ntrib	uted	l to t	he ac	ciden	it or	likely	y to a	aggr	avat	te hi	S	 	
8.	Was the Claimant hospitalized	d? If so f	or what	perio	d?																		 	
9.	What treatment was given an	d Opera	ations pe	erform	ied? _																		 	
10.	Give all dates of treatment :	Clini	c/Hospit	tal:	Fror	n								Тс)									
		Hom																						
11.	Was he under the influence o	fintoxic	ants or	drugs																				
12.	Are you his usual medical Att	endant?																					 	
	If you have treated him for a	ny previ	ous illne	ess or i	injury,	, plea	ise gi	ive d	etail	s													 	
13.	Have other Doctors been in A	ttendan	ice or Co	onsulta	ation?																		 	
	If yes, Please give details																						 	
14.	Has this accident been report	ed to th	e Police	Autho	orities	? If ye	es, C	ase l	No: _						Polic	e Sta	atior	ו					 	
15.	Is this claimant Totally Disable	ed from	each an	ıd ever	у осс	upati	on?																 	
16.	(a) How long was or will the	claimant	t be tota	ally dis	abled	from	n cur	rent	occu	ipatio	on?													
	From		_To																					
	(b)How long was or will the c	laimant	be parti	ially di	sable	d fror	n cu	rren	t occ	upati	ion?													
	From		_То																					
	(c) Estimated date of return t	o Work.																						
17.	What is the Prognosis?																						 	
<u> </u>	tor's Signature									-	104							De-	NI -					
	ctor's Signature									L	ate:						_	кеgr	I NO	·				
	ctors Name																			_		4		
Ado	dress and Phone No.														Pho	one								

Tata AIG General Insurance Company LimitedRegistered 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) CIN:U85110MH2000PLC128425 Insurance is the subject matter of the solicitation