# 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 ______

Age ______ yrs. Occupation ______

## 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 ______ % ______ (In words)

## 4. WITNESSES

1) Name ______

Address ______

City ______

State ______ PIN ______

Phone ______ Mobile ______

2) Name ______

Address ______

City ______

State ______ PIN ______

Phone ______ Mobile ______

## 5. TREATMENT DETAILS

A. Name of Casualty Doctor

Address

Phone — Registration No.

B. Name of Family Doctor

Address

Phone — Registration No.

C. Name ofHospital

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@tata-aig.com or visit www.tataaiginsurance.in
Contact us on our 24 hour Toll Free Helpline at 1800 266 7780 or 1800 22 9966 (only for senior citizen policy holders)
Insurance is the subject matter of the solicitation