Accidental Injury Claim
Claimant's Statement

Form 'A'

INSURED INFORMATION

Insured's Name_____ Date of Birth ___/____/____ Marital Status ____

Insured's Address _____ Phone No. (Off)_____

_____ Phone No. (Res)_____

Name and address of employer
_____

Policy Number _____ Insured's Occupation
_____

Does the insured have any other insurance ? _____If yes, please list all companies, type of insurance, policy numbers and insurance amounts:_____
_____
_____
_____

CLAIM INFORMATION

Date of accident _____/_____/_____ Time and place accident occurred_____

Please describe in detail the circumstances of accident (attach separate sheet if needed): _____

_____
_____

Was the accident related to the Insured's occupation? _____ If so, how? _____

Please describe the nature of Insured's injuries:_____

Please list the names and addresses of all treating physicians and hospitals:_____

_____
_____

_____
_____

Did police or other authorities investigate the accident? ____ If yes, please provide name, address and telephone number of all investigating officers and agencies:
_____
___

CLAIMANT INFORMATION (If different than "Insured Information" above)

Claimant's Name_____ Age_____ Relationship to Insured_____

Claimant's Address_____ Phone No. (Off) _____

_____ Phone No. (Res)_____

In what capacity are you making this claim?
_____

AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by HDFC ERGO General Insurance, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Claimant or authorized person) _____
DATE ____/____/____

To be filled only in case of claim under broken bones section of the policy

CLAIM INFORMATION

Section of claim:

Broken Bones Rehabilitation Benefit Mobility Extension

Date of accident:_____ Place of accident:_____
Please provide details of the accident:_____
_____

Please provide details of the injury:_____
_____

A) Broken Bones Portion of the Body:_____ Nature of Fracture:_____

Name of the attending Physician:_____

Address:_____ Phone No. :_____
Registration No. :_____

Details of the Amount claimed :_____

B) Rehabilitation Benefit
Date on which rehabilitation started :_____
Please provide details of the rehabilitation**:**_____
_____
Name of the Physiotherapist:_____
Address:_____ Phone No. :_____
Registration No. :_____
Name of the Institute(if applicable)_____
Address:_____ Phone No. :_____
Registration No._____

Details of the Amount claimed:_____

C) Mobility Extension
Nature of mobility extension required **:**_____
_____
Total costs of equipment and installation:_____
Details of the Amount claimed:_____

Date: Signature:

Form 'D'

Accidental Injury
Attending Physician's Statement

INSURED INFORMATION

Insured's Name_____ Date of Birth ____/____/___ Marital Status _____

Insured's Address_____ Phone No. (H)_____

_____ Phone No. (W)_____

Name and address of employer
_____

Policy Number_____ Insured's Occupation
_____

CLAIM INFORMATION

Date of accident: ____/ ____/____ Date of first treatment: _____/_____/_____

Please describe in detail the nature of the Insured's injuries,
_____
_____
_____
_____

Was the accident related to the Insured's occupation? _____ If so, how?
_____

Was the Insured hospitalized? _____ If yes, please list the names and addresses of all hospitals and all admission/discharge dates:
_____
_____
_____
_____

Did the Insured have any injury or illness prior to the accident that contributed to the accident or to the Insured's present condition? ____
If yes, please describe:
_____
_
_____
_____

Were any surgical procedures performed? _____ If yes, please list all procedures, and dates performed**:**
_____
_____

_____

What are the Insured's current subjective symptoms?
_____
_____
_____

What are the objective findings? (please include results of current x-rays, lab tests, etc.,)?
_____
_____
_____

Dates of Permanent total disability: Dates of Temporary total disability:

From: _____/_____/_____ To: ____/____/____ From: _____/_____/_____ To: _____/_____/_____

Date Insured able to return to work: _____/_____/_____

Was the Insured seen by any other physician? _____ If yes, please list the names and addresses of all other physicians:
_____
_____
_____
_____