Claim Form Part A - Personal Accident

SECTION A

1. Details of the Proposer:

a) Policy No.:

b) Name of the Insured:

c) Date of Birth: D D M M Y Y Y Y

d) Marital status: ☐ Married ☐ Unmarried

e) Occupation: ☐ Service ☐ Self Employed ☐ Home-Maker
☐ Student ☐ Retired ☐ Student ☐ Others

f) Phone No:

Mobile Home Work

g) Email id:

h) Gross annual Income:

2. Details of Claimant:

a) Name of Claimant:

b) Relationship with Proposer:

c) Address:

d) DOB: D D M M Y Y Y Y

e) Occupation: ☐ Service ☐ Self Employed ☐ Home-Maker
☐ Student ☐ Retired ☐ Student ☐ Others

f) Phone No:

Mobile Home Work

g) Email id:

h) Name of Employer (In case Employed)

i) Gross annual Income:

3. Details of Incidence/Accident/Claim:

a) Date: D D M M Y Y Y Y Time of injury/death:

b) Place/Address of accident/death:

c) Whether the injury is: - (Please tick)

☐ Self-inflicted ☐ road traffic accident ☐ substance abuse ☐ alcohol abuse

d) Details of the accident and nature of accident (Continue on a separate sheet if necessary):

e) Did the accident happen when you were working? ☐ Yes ☐ No

i) If Yes: Name & address of Employer:

f) Whether reported to Police: ☐ Yes ☐ No

i) If Yes: Name and address of Police Station

ii) If not, please give reasons

iii) Medico-legal certificate & FIR attached: ☐ Yes ☐ No

iv) Contact details of Police Station:

4. Details of hospitalisation:

a) Was the Insured Person moved to hospital immediately after the accident:

☐ Yes ☐ No (If yes; complete the following)

I) Name & address of the Hospital:

ii) Date of Admission: D D M M Y Y Y Y iii) Date of Discharge: D D M M Y Y Y Y

b) Details of Treatment to be claimed

Hospitalisation expense: Ambulance charges:

Others: Total:

5. Details of Witnesses

a) Were there any witnesses to the event? ☐ Yes ☐ No (If yes; complete the following)

b) Name of Witness

c) Address of Witness

d) Place of Witness

e) Phone No:

Mobile Home Work

f) Please attach all witness statements if already obtained. In case of further witnesses please use separate sheet.

6. Details of Any other Personal Accident Insurance:

a) Whether the Claimant is covered in Any other Insurance:

☐ Yes ☐ No? (If Yes, please complete the following)

b) Name & Address of the insurer and issuing office:

c) Policy Number

d) Policy Period e) Sum Insured

f) Claim details (if any)

7. Benefit availed:

Sr. No	Name of Benefit	Select
	Section A	
i.	Accidental Death (AD)	
ii.	Permanent Total Disablement (PTD)	
iii.	Permanent Partial Disablement (PPD)	

iv.	Education Benefit	
v.	Emergency Road Ambulance Cover	
vi.	Funeral Expenses	
vii.	Repatriation of Remains	
viii.	Orphan Benefit	
ix.	Modification Benefit (Residence and vehicle)	
x.	Compassionate visit	
xi.	P.A. Cumulative Bonus	
	Section B	
i.	Temporary Total Disablement	
ii.	Accidental in-patient hospitalization (In India)	
iii.	Broken Bones Benefit	
iv.	Coma Benefit	
v.	Burns Benefit	
vi.	Accidental Medical Expenses (In India)	
vii.	Adventure Sports Cover	
viii.	Worldwide Emergency Assistance Services (including Air Ambulance)	
ix.	EMI Protect	
x.	Loan Protect	

8. Details of Bills Enclosed:

Sl. No.	Bill No	Date			Issued by	Towards	Amount (Rs)
		MM	DD	YY			
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

9. Common Claim Documents to be submitted for all Personal Accident Claims (All documents are required in Original / Self Attested / Document collected via Electronic Medium / Any other mode suggested by company from time to time):

a) Claim Form duly completed and signed as prescribed by Us
b) Photo ID and Age proof of insured person / Nominee (if insured person is not alive)
c) Claim intimation or claim reference number (if any)
d) Medico Legal Certificate copy / First Information Report copy / Panchnama (spot / inquest)
e) Consultation letters detailing the treatment taken immediately after Accident
f) Radiological investigation reports like X ray, CT scan, MRI etc with films supporting the diagnosis of Injury
g) Cancelled cheque for NEFT

Documents required in addition for Specific Benefits under Personal Accident (All documents are required in Original / Self Attested / Document collected via Electronic Medium / Any other mode suggested by company from time to time)

1) Accidental Death
   a) Death certificate issued by Government / Municipal Authorities
   b) Cause of death certificate issued by treating Medical Practitioner/ Hospital
   c) Burial certificate (wherever applicable)
   d) Post-mortem Report.
   e) Viscera report and chemical analysis report
   f) Witness statement (if available)
   g) Death Summary if the insured person was hospitalised
   h) Indoor case papers with nursing sheet detailing medical history of the patient, treatment details and patient's progress (where the Death Summary is not detailed)
   i) Translation of all vernacular documents in English duly notarized.
   j) Salary slips for last 3 months with seal and signature of authorized signatory of the organization (if employed)
   k) Last 3 years financial years Income Tax Return for self-employed persons
   l) Legal heir certificate containing affidavit and indemnity bond both duly signed by all legal heirs and notarized (If Nominee name is not mentioned on Policy Schedule or Certificate of Insurance or Nominee is a minor, then legal guardian.)

2) Permanent Total Disablement / Permanent Partial Disablement
   a) Disability certificate issued by Civil Surgeon of District Hospital mentioning the type and percentage of disability.
   b) Photograph of the Insured Person reflecting the disablement or injured part for which the claim is made
   c) Leave records with seal and signature of authorized signatory of the organization (if employed)
   d) Salary slips for last 3 months with seal and signature of authorized signatory of the organization (if employed)
   e) Last 3 years financial years Income Tax Return for self-employed persons
   f) Medical documents towards treatment taken during disability period, including discharge summary of the Hospital
   g) Indoor case papers with nursing sheet detailing medical history of the patient, treatment details and patient's progress (where the Discharge Summary is not detailed)

3) Education Benefit
   a) Document pertaining to the section under which the benefit is payable i.e. Accidental Death and Permanent Total Disablement
   b) Proof of relationship with the Insured and Age proof of the dependent child
   c) Proof that the Dependent Child is pursuing educational course as a full time student

4) Emergency Road Ambulance Cover:
   a) Invoice and paid receipt from the register Ambulance carrier.

5) Funeral Expenses:
   a) All documents listed under Accidental Death benefit, invoice and payment receipt for expenses incurred during funeral.

6) Repatriation of Remains:
   a) All documents listed under Accidental Death benefit
   b) Proof of Repatriation (bills and payment receipt of transportation)

7) Orphan Benefit:
   a) All documents listed under Accidental Death Benefit
   b) Age proof of the surviving dependent child

8) Modification Benefit (Residence):
   a) All documents listed under Permanent Total Disablement / Permanent Partial Disablement
   b) Bills and payment receipt of actual expenses incurred towards improvements carried out in the Insured Person's residence following the Insured Person's disablement

Modification Benefit (Vehicle):
   a) All documents listed under Permanent Total Disablement / Permanent Partial Disablement
   b) Bills and payment receipt of actual expenses incurred towards improvements carried out in the Insured Person's or vehicle following the Insured Person's disablement

9) Compassionate Visit:
   a) All documents listed under Accidental Death, Permanent Total Disablement, Permanent Partial Disablement Benefit
   b) Ticket of the immediate relative of the Insured Person to travel to the place of Hospitalization of the Insured Person
   c) Bills and payment receipt for travel expense incurred
   d) Proof of the relationship of the 'immediate relative' as defined in the Policy (such as marriage certificate, ration card)

10) Temporary Total Disablement
   a) Disability certificate issued by Civil Surgeon of District Hospital / Treating medical practitioner mentioning the type and percentage of disability with disability period
   b) Photograph of the Insured Person reflecting the disablement or injured part for which the claim is made
   c) Leave records with seal and signature of authorized signatory of the organization (if employed)
   d) Salary slips for last 3 months with seal and signature of authorized signatory of the organization (if employed)
   e) Last 3 years financial years Income Tax Return for self-employed persons
   h) Medical documents towards treatment taken during disability period, including discharge summary of the Hospital
   f) Indoor case papers with nursing sheet detailing medical history of the patient, treatment details and patient's progress (where the Discharge Summary is not detailed)

11) Accidental In-patient Hospitalization (limited to India)
   a) Hospital Discharge Summary / Day care summary / Transfer summary
   b) Final Hospital bill with all deposit and final payment receipt.
   c) Invoice with payment receipt and implant stickers for all implants used during Surgeries i.e. sticker & invoice of nails, plates, screws, wires, implants, etc.
   d) All diagnostic reports (including imaging and laboratory) along with the Medical Practitioner's prescription and invoice / bill with receipt from diagnostic center.
   e) All medicine / pharmacy bills along with the Medical Practitioner's prescription.
   f) Medico legal certificate copy / first information report copy
   g) Death summary and death certificate (in death claims only)
   h) Pre and post- operative imaging reports – where applicable
   i) Hospital's registration certificate / copy of Form C in case of Hospitalization
   j) Indoor case papers with nursing sheet detailing medical history of the patient, treatment details and patient's progress (where the Discharge Summary is not in detail)

   For Contribution Claims Only:
   k) Photocopy of entire claim document duly attested by previous insurer or TPA.
   l) Payment receipts for expenses not claimed/settled by the previous insurer.
   m) Discharge voucher/settlement letter by previous insurer.

12) Broken Bones Benefit:
   a) All documents listed under Permanent Total Disablement (under Section II.2) / Permanent Partial Disablement (under Section II.3) and Temporary Total Disablement (under Section II.4)
   b) All diagnostic reports (including imaging and laboratory) along with Medical Practitioner's prescription and invoice / bill with receipt from diagnostic center
   c) Pre and Post-Operative radiological imaging reports with films confirming the extent of the fracture
   d) Medico Legal Certificate copy / First Information Report copy / Panchnama (spot / inquest)
   e) Medical documents / Hospital records evidencing the fracture.

13) Coma Benefit:
   a) All documents listed under Permanent Total Disablement / Permanent Partial Disablement
   b) Condition of coma as confirmed by a Specialist Medical Practitioner which documents:
      a. No response to external stimuli continuously for at least 96 hours
      b. Life support measures are necessary to sustain life
      c. Cause of coma
      d. Whether coma has resulted from alcohol consumption or any intoxicating substance
      e. Clinical summary of the comatose patient (discharge card / day care summary / transfer summary)

14) Burns Benefit:
   a) Treating doctor's certificate stating:
      I. Incident Details of accident / trauma.
      ii. Degree of Burns & Extent of area involved
      iii.Cause of Burns whether Accidental or Self Inflicted

iv. Whether the patient was under the influence of alcohol or any intoxicating substance during incident / accident.
v. Photo of the Burns

b) Medico Legal Certificate copy / First Information Report Copy

15) Accidental Medical Expenses Cover:
a) medicine prescription and advice from treating Medical Practitioner
b) invoices, bills, receipts of Medical Practitioner consultations / laboratory reports / radiology investigations / pharmacy bills / investigation report

16) Adventure Sport Cover:
a) Documents listed under Accidental Death / Permanent Total Disablement Benefit

17) EMI Protect:
a) Documents listed under Accidental Death / Permanent Total Disablement Benefit / Permanent Partial Disability
b) Current Outstanding Loan Certificate from financer, along with copies of documents submitted
c) Loan disbursement letter along with payment record till the date of accident
d) Repayment schedule showing the EMI details
e) Medical fitness certificate from treating doctor confirming the date to resume the duties (required in case of Permanent Partial Disability claims only)

18) Loan Protect:
a) Documents listed under Accidental Death / Permanent Total Disablement Benefit
b) Current Outstanding Loan Certificate from financer, along with copies of documents submitted
c) Loan disbursement letter along with payment record till the date of accident
d) Repayment schedule showing the EMI details

10. Details of Policyholder's Bank Account

This details needs to be furnished with cancelled cheque on the same account:

a) Bank Name:

b) Branch Name:

c) Bank Account Number:

d) IFSC Code: e) MICR No.:

[Please attach copy of a cancelled blank cheque of your bank for ensuring accuracy of name of the Bank, Branch name, Account number and IFSC code. If name of the policyholder is not printed on the cheque please attach copy of the first page of the bank passbook/copy of bank statement also]

11. Details of Nominee

To be completed by Nominee in the event of Policyholder's death

i. Name of Nominee:

ii. Address:

iii. Date of Birth: D D M M Y Y Y Y

iv. Relationship with the deceased:

v. Phone No:

Mobile Home Work

vi. E-Mail:

12. Declarations:

I/We hereby warrant that:
(1) I have read and understood the policy terms, conditions and exclusions
(2) The foregoing particulars are true and complete in all material respects.
(3) I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim.

(Below declaration is to be collected from the claimant only in case of online / electronic claims submission where original documents are not submitted with Us)

"I further undertake that in consideration of You (ABHI) agreeing to process my claim based on scanned copy / photographs of medical prescription and receipt, I hereby confirm and undertake to preserve all the original documents, scanned copies / photos of which are submitted for the claim for a period of one year from the settlement of my claim and also agree to provide original copies of the same as and when required by You."

Date: D D M M Y Y Y Y

Place:

Signature of the Insured/ Policyholder/ Nominee

SECTION A

To be completed by the Doctor who originally treated the injuries

1. Name and address of the Insured Person:
2. Gender: Male Female
3. Date of Birth: D D M M Y Y Y Y age:
4. Are you the patient's usual Medical Practitioner? Yes No
   a) If yes, since when? D D M M Y Y Y Y
   b) If you have treated him/her for any previous Illness or Injury, please give details:
5. Has the patient sustained a similar injury previously or aggravated a Pre-Existing Disease? Yes No
6. Describe nature and extent of Injury:
   E.g. If limb or eye is injured, please state whether right or left:
7. Describe the Incident (how, when and where did the Injury / Accident occur)
8. Nature and cause of Accident (so far as it is known to you):
9. Are his/her Injuries
   a) Solely due to the Accident? Yes No
   b) Traceable to any disease, infirmity previous Injuries or any other cause? Yes No
   c) If yes, please give details:
10. Injuries sustained in this Accident are the only cause of disablement?
11. Date you first examined the patient for this Injury: D D M M Y Y Y Y
12. If admitted in Hospital: Date of Admission: D D M M Y Y Y Y Date of Discharge: D D M M Y Y Y Y
13. According to you, how long should the Insured Person be confined to bed/house as the direct and sole consequence of the Injury sustained? From: D D M M Y Y Y Y To: D D M M Y Y Y Y
    a) During this period will the Insured Person be able to attend to his/her normal duties? Yes No
    b) If Yes, from what date: D D M M Y Y Y Y
    c) If No, please state probable date of his/her being able to attend to his/her normal duties: D D M M Y Y Y Y

14. 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? ☐ Yes ☐ No

a) If yes: Give particulars:

15. Present Condition:

16. Treatment detail with name of drugs and route of administration of such drugs

17. Was he/she under the influence of alcohol or any inebriating drugs or any other addictive substance during the Accident or not?

18. Whether the Injury sustained is Accidental or intentional self Injury

19. Nature of disablement

a) Permanent Total Disablement ☐ Yes ☐ No b) Permanent Partial Disablement ☐ Yes ☐ No

c) Other ☐ Yes ☐ No d) Please specify percentage: ☐☐☐ %

I have personally examined the above named Insured Person. I certify that the above statements are correct and that the Insured Person is necessarily disabled by the Accident.

Date: D D M M Y Y Y Y

Place:

Stamp:

Signature of the Medical Practitioner:

Name & Qualification:

Registration Number:

Address:

Telephone No.: Mobile No.:

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the hospital)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A – 1. DETAILS OF PROPOSER		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) Name of Proposer	Enter the Full Name of the Patient	First Name, Middle Name, Surname
c) Address	Enter the Full Postal Address	Include Street, City, State and Pin Code
d) Date of Birth	Enter Date of Birth of Policyholder	Use DD/MM/YYYY format
e) Marital Status	Select the correct option	Tick the right option
f) Occupation	Indicate Occupation of Patient	Please specify the Occupation
g) Telephone Number	Enter the Phone Number of Policyholder	Include STD code with telephone number
h) Mobile No.	Enter the phone number of doctor	Please enter a 10 digit number
I) E-mail Address	Enter E-mail Address of Policyholder	Complete E-mail Address
2. DETAILS OF THE CLAIMANT		
a) Name of Claimant	Enter the name of patient	First Name, Middle Name, Surname
b) Relationship with Proposer	Indicate Relationship of Insured with Policyholder	Please specify the relationship

c) Address	Enter the Full Postal Address	Include Street, City, State and Pin Code
d) Date of Birth	Enter Date of Birth of Policyholder	Use DD/MM/YYYY format
e) Occupation	Indicate Occupation of Patient	Please specify the Occupation
f) Telephone Number	Enter the Phone Number of Policyholder	Include STD code with telephone number
g) Mobile No.	Enter the phone number of doctor	Please enter a 10 digit number
h) E-mail Address	Enter E-mail Address of Policyholder	Complete E-mail Address
i) Name of employer	Enter the Name of Employer	Please Enter the Name of Employer
j) Gross Annual Income	Enter the Annual Gross Salary	Use INR
3. DETAILS OF THE INCIDENCE		
a) Date (DD/MM/YYYY) and Time of Injury/ Death	Enter the Date of Injury/ Death	Use DD/MM/YYYY format
b) Place of Accident/ Injury/ Death	Enter the Place where the Accident/ Injury or Death Occurred	Enter Locality, City, State
c) Whether the injury is :- Self-inflicted / road traffic accident / substance abuse / alcohol abuse	Select the correct option	Tick the right option
d) Details and Nature of Accident	Enter details of reason and nature of Accidental Injuries	Describe the nature of Injuries and reason for Accident
e) Did the accident happen when you were working? Yes / No	Select the correct option	Tick the right option
i) If Yes, Name and Address of Employer	Indicate the Full Postal Address	Include Street, City, State and Pin Code
f) Whether reported to Police	Indicate Whether you have informed & reported to Police	Tick Yes or No
i) If Yes, Name and Address of Police Station	Indicate the Full Postal Address	Include Street, City, State and Pin Code
ii) If No, Give reasons	Indicate the reason for Not informing the Police	Indicate the reason for Not informing the Police
iii) First Information Report (FIR) Number & Date	Indicate the FIR number	Please give complete FIR number
iv) Contact Details of Police Station	Indicate the Telephone number and address of Police Station	Include STD code with telephone number/Address-Include Street, City, State & Pin Code
4. DETAILS OF HOSPITALISATION		
a) Was the Insured Person moved to hospital immediately after the accident: Yes / No (If yes; complete the following	Select the correct option	Tick the right option
I) Name of the hospital:	Enter the name of hospital	Name of the hospital in full
ii) Date of Admission	Enter date of Admission	Use dd-mm-yy format
iii) Date of Discharge	Enter date of Discharge	Use dd-mm-yy format
b) Details of Treatment to be claimed Hospitalisation expenses	Amount to be filled in number	Enter in INR
Ambulances charges	Amount to be filled in number	Enter in INR
Others	Amount to be filled in number	Enter in INR

5. DETAILS OF WITNESS		
a) Were there any witnesses to the event?	Indicate whether there was any witness	Tick Yes or No
b) Name of Witness	Enter the Full Name of the Witness	First Name, Middle Name, Surname
c) Address of witness	Indicate the Full Postal Address	Include Street, City, State and Pin Code
d) Place Of witness	City Location	City
e)Telephone Number	Enter the Phone Number of Policyholder	Include STD code with telephone number
f) Mobile No.	Enter the phone number of doctor	Please enter a 10 digit number
6. DETAILS OF ANY OTHER PERSONAL ACCIDENT INSURANCE		
a) Whether the Claimant is covered in Any other Insurance: Yes/No? (If Yes, please complete the following)	Select the correct option	Tick the right option
a) Name of the Insurer	Indicate Full Name	Name - Enter Full Name
b) Address of Issuing office	Indicate Address of Insurer's Issuing office	Include Street, City, State and Pin Code
c) Policy Number	Enter the Policy Number	As allotted by the Insurance Company
d) Policy Period	Enter the Policy Commencement and End Date	DD/MM/YYYY to DD/MM/YYYY
e) Sum Insured	Enter the Total Sum Insured as per the Policy	In Rupees
7. DETAILS OF BENEFIT TO BE AVAILED		
Please Indicate and Tick the Benefits claimed		
8. DETAILS OF BILLS ENCLOSED		
Please fill in details of bills enclosed		
9. DETAILS OF DOCUMENTS TO BE SUBMITTED		
Indicate which supporting documents are submitted		
10. DETAILS OF POLICYHOLDERS BANK ACCOUNT		
a) Bank Name	Enter the Bank Name	Name of the Bank in full
b) Bank Branch	Enter Name of the Branch	Name of the Branch
c) Bank Account Number	Enter the Bank Account Number	As allotted by the Bank
d) IFSC Code	Enter the IFSC Code of the Bank Branch	IFSC Code of the Bank Branch in full
e) MICR Code	Enter the MICR Code	MICR Code of the Bank Branch in full
Claim payment option	Please select desired option	Tick desired option
11. DETAILS OF NOMINEE		
Nominee to fill in relevant details (Applicable in case of Policyholder’s death)		
12. DECLARATION		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. and stamp		

Customer Identification Procedure (As per KYC norms of IRDAI)

Please submit a clear and legible copy of one document (valid and effective as on the date of claim submission) each from Part A and Part B and your recent passport size photograph (not more than 6 months old) in case the claim exceeds Rs 100,000

Part A: Proof of legal name and any other names:

1. PAN CARD
2. If PAN CARD not available then please submit any of the documents mentioned below stating reason for not having Pan Card
   a. Passport
   b. Voter's Identity Card
   c. Driving License
   d. Personal Identification and Certification of the employees for your identity
   e. Letter issued by Unique identification Authority of India containing details of name address and Aadhar Number
   f. Job Card issued by NREGA duly signed by an officer of the State Government
   g. Photograph (not more than 6 months old)

Part B: Proof of Residence:

1. Electricity Bill not older than 6 months from the date of Insurance Contract
2. Telephone Bill pertaining to any kind of telephone connection like mobile, landline, wireless etc. Provided it is not older than 6 months from the date of claim submission
3. Ration Card
4. Valid lease agreement along with rent receipts which is not more than 3 months old as a residence proof
5. Saving Bank Passbook with details of permanent/ present residence address (updated upto 1 month prior to claim submission document)
6. Statement of saving bank account with details of present/ present address (updated upto 1 month prior to claim submission document)

I hereby declare that I have submitted above mentioned documents and recent photograph (not more than 6 months old) for the purpose of claim and the said documents are valid and effective

Date: D D M M Y Y Y Y

Signature of Claimant