Personal Accident Insurance

How to file a Claim

- In case of any event leading to a claim under the policy, please call our Toll-free Number 1800-2-700-700
- Our Claims Service Representative will guide you on the claim procedures and documents Required
- Complete the claim form relevant to the nature of loss as indicated below.
- Attach the documents mentioned against the claim type

For Accidental Injury Claims

1. Claim form as per 'Form A+ D'
2. Police FIR, if accident is reported to Police
3. Medical papers, pathology reports, X-ray reports, as applicable
4. For Permanent Disability Claims – disability certificate from reputed surgeon or Municipal Hospital
5. For Temporary Total Disability Claims-sick leave certificate from Employer
6. Attending Physician's statement as per 'Form D'

- Our Claims Service Representative may visit you in the Hospital or at Home to personally collect claim documents.
- Documents, in addition to those mentioned above maybe called for, depending on the nature of accident and claim lodged.
- Please retain a copy of the documents sent for your records.

6th Floor, Leela Business Park, Andheri-Kurla Road, Andheri (East), Mumbai 400 059. Toll-free No. 1800-2-700-700 Fax: 91 22 6638 3699 care@hdfcergo.com www.hdfcergo.com
Registered Office: Ramon House, H. T. Parekh Marg, 169, Backbay Reclamation, Mumbai 400 020.

HDFC ERGO General Insurance Company Limited

Form 'A'

Accidental Injury Claim

Claimant's Statement

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 ____/____/____

HDFC ERGO General Insurance Company Limited

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:** ________________

____
____

ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician: ____ **Phone No.** ________________________

Address:
____
____

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SIGN WITH STAMP (Attending Physician) ____
DATE