

HDFC ERGO General Insurance Company Limited



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 _____

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



Accidental Medical Expense Insured's Statement

Form 'B'

INSURED INFORMATION

Insured's Name _____

Insured's Address _____

Phone No. (Off) _____ Phone No. (Res) _____

Policy Number _____

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: _____

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

Please list the names and addresses of all treating/consulting physicians or other healthcare providers:

Name	Street Address	City	State	Pin Code	Phone

If hospitalized, please provide name and address of hospital(s) where treatment was received: _____

Do you have any other insurance that may provide coverage for this accident or loss? ____ If yes, please identify name, address, and policy number of all other insurance: _____

AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other person who may have knowledge regarding this claim 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 (Insured or authorized person) _____ Date ____ / ____ / ____

CERTIFICATION OF NO OTHER INSURANCE

I, _____ hereby certify that I have no other accident or health insurance or any other insurance covering this loss.

Signed (Insured or authorized person) _____ Dated ____ / ____ / ____

HDFC ERGO General Insurance Company Limited



Hospital Cash Plan Claim Form

Form 'C'

(N.B. To be filled in by the Insured Policy holder, or Insured's authorised representative enjoying power of attorney. Issuance of this claim form is not be taken as admission of liability)

PART I-Insured Information

Name of Policy holder :	
Name of Employee/Member : (For group insurance policy only)	Policy No. :
Insured No./Certificate No. (If applicable):	
Name of Patient:	I.D. Card No. :
Occupation :	Date of Birth :
Relationship to the Policy holder:	Self Staff/Member Spouse Dependent Child
(1) Have you had any prior treatment for this or related conditions?	
NO <input type="checkbox"/> YES <input type="checkbox"/> Doctor's Name : _____	
Address : _____	
Date(s) : _____	
(2) Are you making any other insurance claim as a result of this hospitalization/surgery?	
NO <input type="checkbox"/> YES <input type="checkbox"/> Name of Insurance Company : _____	
Policy No. : _____	
(3) (a) Was the hospitalization/surgery a result of an accident?	
NO <input type="checkbox"/> YES <input type="checkbox"/> _____	
(3) (b) Date of accident ____/____/____ Time and place accident occurred _____	
Please describe in detail the circumstances of accident(attach separates heet if needed): _____	
4) Hospitalization	
Name of hospital : _____	
Date of admission: _____	Date of Discharge : _____
I/We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and I/We agree if I/We have made, or in any further declaration the Company may require in respect of the said claim, shall make any false or fraudulent statement, or any suppression or concealment the Policy shall be void and all rights to recover thereunder in respect of past or future claims shall be forfeited	
AUTHORISATION	
I HEREBY AUTHORISE on behalf of the patient: (1) Any employer, medical practitioner, hospital, clinic, insurance company, bank, government institution, or other organisation, institution or person, that has any records or knowledge of the patient and/or who has attended or may hereafter attend the patient to disclose such information to HDFC ERGO General Insurance Company; (2) HDFC ERGO General Insurance Company or any of its appointed medical examiners or laboratories to perform the necessary medical assessment and tests to evaluate the health status of the patient in relation to this claim. This authorisation shall bind the patient.s successors and remains valid notwithstanding death or incapacity. A photocopy of this authorisation shall be as valid as the original.	
_____	_____
Date Place:	Signature of Patient

**Accidental Injury
Hospital Cash Claim (Accident or Sickness)
Attending Physician's Statement**

Form'D'

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, labtests, etc.,)? _____ _____
Dates of total disability: _____ Dates of partial 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: _____	
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(AttendingPhysician) _____	DATE ___/___/___

Accidental Death Claimant's Statement

Form'E'

INSURED INFORMATION

Insured's Name _____ Date of Birth ___ / ___ / ___ Marital Status _____

Insured's Address _____

Name and address of Last Employer _____

Policy Number _____ Insured's Occupation (at time of death) _____

Did the Insured have any other accident or life insurance? _____ If yes, please list all companies, 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 cause of the Insured's death:

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: _____

Was an autopsy performed? _____ If yes, please provide name and address of Medical Examiner _____

Was a coroner's inquest held? _____ If yes, what was the determination? _____

CLAIMANT INFORMATION

Claimant's Name _____ Age _____ Relationship to Insured _____

Claimant's Address _____ Phone No.(H) _____

Phone No.(W) _____

In what capacity are you making this claim? _____ Beneficiary _____ Executor* _____ Administrator* _____ Guardian* _____
Trustee* _____ Assignee*

*Please provide a certified copy of all documents supporting your authority (e.g., Succession Certificate, Notarised Affidavit, Notarised will, etc.) 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.

Place: _____

DATE ___ / ___ / ___

SIGNED(Claimant or authorized person)