Group Health-Personal Accident Claim Form

(The issue of this Form is not to be taken as an admission of liability)

HDFC Life
Sar utha ke jiyo!

PART A: *To be filled by Life Insured or Claimant*

For which benefit is the claim made?

a) Accidental Death ☐ b) Permanent total disablement ☐ c) Permanent partial disablement ☐

1. Details of Claimant

a) Policy Number (in full): _____

b) Name of the Claimant : _____

c) Address: _____

_____

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

e) Gender: ☐ Male ☐ Female

f) E-mail ID*: _____

g) Contact number*: ☐☐ OFFICE ☐☐☐☐ ☐☐☐ MOBILE ☐☐☐

h) Relationship with the Life Insured: _____

**Contact details provided herein will be updated for all future communications. The above mentioned contact number will be considered as consent to communicate with me on the contact details provided herein.*

2. Details of Life Insured *(in respect of whom the claim is made)*

a) Name of the Life Insured: _____

b) Address: _____

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

d) Occupation: ☐ Service ☐ Business ☐ Self-Employed ☐ House wife ☐ Others _____

e) Gender: ☐ Male ☐ Female

f) Contact number: ☐☐ OFFICE ☐☐☐☐ ☐☐☐ MOBILE ☐☐☐

g) E-maill ID: _____

h) Employee ID (If applicable): _____

i) Name of the Master Policyholder: _____

j) Member No./Client ID: _____

3. Details of Claim

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

c) Place/Address of accident/Death: _____

d) Please describe in detail the circumstances of accident (enclose/attach separate sheets if needed): _____

_____

_____

d) Was the accident related to the Life Insured's occupation? ☐ Yes ☐ No

If yes, how?: _____

e) Please describe the nature of the Life Insured's injuries: _____

_____

_____

f) Whether reported to police? ☐ Yes ☐ No

g) If yes, name and address of police station: _____

ii) If not, please give reason(s): _____

_____

iii) First Information Report (FIR) and date: _____

h) Contact details of police station/investigation officers: _____

i) Was the Insured person moved to hospital immediately after the accident? ☐ Yes ☐ No

If yes, name and address of the hospital: _____

Date of admission : D D M M Y Y

Date of discharge : D D M M Y Y

j) Do you have any other personal accident policy? ☐ Yes ☐ No (if yes, please complete the following):

Name and address of the Insurer and issuing office: _____

Policy No.: _____

Policy Period: _____

Sum Insured (INR): _____

4. Consent for Mode of Claim Payment

Name of the Life Insured: _____

Policy No.: _____

Claim No.: _____

Insured/Claimant Name: _____

Following fields are mandatory

Name of the Life Insured/ Claimant as per Bank Account: _____

Bank Account No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Bank & Branch Name: _____

IFSC : ☐☐☐☐☐☐☐☐☐☐☐

E-mail address: _____

Enclosure/Attachments: ☐ Cancelled Cheque ☐ Bank Passbook Copy ☐ (in support of bank details)

Declaration:

I, Mr./Mrs./Ms. _____, the undersigned, legal Beneficiary of the above claim, declare that all details mentioned in this form are true and I agree to the mode of payment against the particular claim no. mentioned above.

Date: DD/MM/YYYY

Place: _____

SIGN HERE

(Stamp Required in case of Company)

Signature of Beneficiary

5. Authorisation

I authorise any insurance company physician, hospital or other healthcare provider or any other organisation, institution or person that may have records, documents or documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand that this information will be used by HDFC Life (the Company) or its authorised representatives for the purpose of evaluating and determining coverage for this claim. I am aware that I have a right to receive a copy of this authorisation upon request and agree that a photographic or facsimile copy of this authorisation as valid as original. I agree that this authorisation shall be valid for 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 material false, incomplete or misleading information will be subject to prosecution for insurance fraud.

I hereby understand, declare, consent and authorise the Company that personal health details, medical history and financial information, as provided to the Company may be utilised for processing the claim made under the policy. Thereby also understand, declare and consent that the Company shall have right to retain and disseminate the same to any service provider for providing services related to insurance.

In addition to postal or courier service, the Company may at its discretion, use any electronic media/registered email ID for communicating with me/us.

Date: DD/MM/YYYY

Place: _____

SIGN HERE

Signature of (Life Insured/Claimant)

6. Consent for updating Client Contact Details

- I hereby provide my consent to HDFC Life to update my address in case the new address proof is submitted at claims stage. All future claim related communications will be made on the revised address.
- I hereby provide my consent to HDFC Life to update my phone number and/or email ID in case new contact details are mentioned in the claim form. All future claim related communications will be made on the revised contact details.

NOTE: New contact details are those which differ from the ones submitted at the time of your application and are available in our records.

Date: DD/MM/YYYY

Place: _____

SIGN HERE

Life Insured/ Claimant

7. Claim Documents Enclosed Checklist: *(Please tick the appropriate box and attach/enclose the mentioned documents)*

List A - Accidental Death:

- ☐ Duly filled and signed claim form
- ☐ Policy copy
- ☐ Copy of FIR/Spot Panchanama/ Inquest Panchanama
- ☐ Death certificate
- ☐ Original death summary
- ☐ Post mortem report
- ☐ Original legal heir certificate (in case nomination has not been filled by the deceased)

List B - Permanent Total Disablement/ Permanent Partial Disablement/ Temporary Total Disablement

- ☐ Duly filled and signed claim form
- ☐ Policy copy
- ☐ Copy of FIR/Spot Panchanama/ Inquest Panchanama
- ☐ Original treating doctor certificate describing disablement
- ☐ Original discharge summary from the hospital
- ☐ Original photograph of the injured reflecting disablement
- ☐ Prescription and consultation papers
- ☐ Leave certificate from the employer (if applicable)
- ☐ Disability certificate issued by Civil Surgeon or equivalent as authorised by State Government
- ☐ Medical reports, case histories, investigation reports, treatment papers as applicable

PART B: *To be completed by the Doctor who originally treated the injuries*

A. Insured Information

a) Policy No. (in full): _____

b) Client ID and Member No.: _____

c) Name of the Insured : _____

d) Address: _____

_____

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

f) Gender: ☐ Male ☐ Female

g) Occupation: ☐ Service ☐ Business ☐ Self-Employed ☐ House wife ☐ Others: _____

h) E-mail ID: _____

i) Contact number: ☐☐ O F F I C E ☐☐☐☐ ☐☐☐ M O B I L E ☐☐☐

j) Employee ID (If applicable) : _____

k) Name of the Master Policyholder: _____

B. Claim Information

a) Date of Accident/Death: D D M M Y Y

b) Date of first treatment: D D M M Y Y

c) Please describe in detail the nature of Insured's injuries: _____

d) Was the accident related to the Insured's occupation?: ☐ Yes ☐ No

If yes, how?: _____

e) Was the Insured hospitalised?: ☐ Yes ☐ No

If yes, please list names and addresses of the hospitals and all admission - discharge dates: _____

_____

f) Did the Insured have any injury or illness prior to the accident that contributed to the accident or to the Insured's present condition?: ☐ Yes ☐ No

If yes, please describe: _____

g) Were any surgical procedures performed?: ☐ Yes ☐ No

If yes, please mention: _____

h) What are the Insured's current objective symptoms?: _____

i) What are the objective findings? (please include results of xrays, lab tests, etc.): _____

j) Dates of Total Disability: From D D M M Y Y To: D D M M Y Y

k) Dates of Partial Disability: From D D M M Y Y To: D D M M Y Y

l) Date on which the Insured was able to return to work: D D M M Y Y

m) Was the Insured seen by any other physician?: ☐ Yes ☐ No

n) If yes, please list the names and addresses of all other physicians: _____

Attending Physician Information

Name: _____

Policy No. (in full): _____

Contact ☐☐OFFICE☐☐☐☐ ☐☐☐MOBILE☐☐☐ No*.:

E mail*: _____

Date: DD/MM/YYYY

Place: _____

SIGN HERE

Signature of Doctor

**Contact details provided herein will be updated for all future communications. The above mentioned contact number will be considered as consent to communicate with me on the contact details provided herein.*

PART C : Accidental Death *(To be completed by the Doctor who originally treated the injuries)*

Insured Information

a) Policy no. (in full): _____

b) Client ID: _____

c) Name of the Policyholder: _____

d) Address: _____

_____

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

f) Gender: ☐ Male ☐ Female

g) Occupation: ☐ Service ☐ Business ☐ Self Employed ☐ House wife ☐ Others: _____

h) E-mail ID: _____

i) Contact number: ☐☐OFFICE☐☐☐☐ ☐☐☐MOBILE☐☐☐

j) Employee ID (If applicable): _____

k) Name of the Master Policyholder: _____

Claim Information

a) Date of Accident/Death: D D M M Y Y

b) Date of first treatment: D D M M Y Y

c) Please describe in detail the nature of Insured's injuries: _____

d) Was the accident related to the Insured occupation? ☐ Yes ☐ No

If so, how?: _____

e) Was the Insured hospitalised?: ☐ Yes ☐ No

If yes, please list the names and addresses of the hospitals and all admission - discharge dates: _____

_____

f) Whether reported to police?: ☐ Yes ☐ No

If yes, name and address of Police Station: _____

g) Was an autopsy performed?: ☐ Yes ☐ No

If yes, please provide the name and address of the medical examiner: _____

h) Was a coroner's inquest held?: ☐ Yes ☐ No

If yes, what was the determination?: _____

Attending Physician Information

Name: _____

Registration _____ No.:

Contact OFFICE MOBILE No*.:

(HDFCLife)

E mail*: _____

Date: DD/MM/YYYY

Place: _____

SIGN HERE

Signature of Doctor

**Contact details provided herein will be updated for all future communications. The above mentioned contact number will be considered as consent to communicate with me on the contact details provided herein.*

Declaration made by third person where the Policyholder/Life Assured/Claimant has affixed his/her thumb impression/has signed Invernacular:

The Policyholder/Life Assured/Claimant has affixed his/her thumb impression/has signed in vernacular/has not filled this form. I hereby declare that the content of this form has been explained to the Policyholder/Life Assured in _____ language and have truthfully recorded the answers provided to me. I further declare that the Policyholder/Life Assured/Claimant has signed/affixed his/her thumb impression in my presence.

Name of the Declarant: _____

Address: _____

Date: DD/MM/YYYY Place: _____

SIGN HERE

Signature of Third Person