

**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. : _____<br>Registration No. : _____<br>Details of the Amount claimed : _____                                                                                                                                                                                                                                                                                                      |
| <b>B) Rehabilitation Benefit</b><br>Date on which rehabilitation started : _____<br>Please provide details of the rehabilitation: _____<br>_____<br>Name of the Physiotherapist: _____<br>Address: _____ Phone No. : _____<br>Registration No. : _____<br>Name of the Institute(if applicable) _____<br>Address: _____ Phone No. : _____<br>Registration No. _____<br>Details of the Amount claimed: _____ |
| <b>C) Mobility Extension</b><br>Nature of mobility extension required : _____<br>_____<br>Total costs of equipment and installation: _____<br>Details of the Amount claimed: _____<br>_____<br>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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_