# Health Insurance
Aditya Birla Health Insurance Co. Limited

ADITYA BIRLA CAPITAL
PROTECTING INVESTING FINANCING ADVISING

## Group Active Secure - Claim Intimation Form - Personal Accident

### SECTION A

**1. Details of the Primary Insured Person:**

a) Policy No. :

b) Name of the Insured Person:

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 ☐ Others

f) Phone No: Mobile  Home  Work

g) Email id:

h) Gross annual Income:  i) Employee ID No

j) Name of Employer

k) Name Entity

**2. Details of Claimant:**

a) Name of Claimant:

b) Relationship with Primary Insured Person:

c) Address:

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

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

f) Phone No: Mobile  Home  Work

g) Email id:

h) 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 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 original 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. Detail of Benefit to be availed:**

| Sr. No | Name of Benefit | |
|---|---|---|
| | **Section A: Basic Covers** | |
| i. | Accidental Death (AD) | |
| ii. | Permanent Total Disablement (PTD) | |
| iii. | Permanent Partial Disablement (PPD) | |
| iv. | Temporary Total Disablement | |
| v. | Recovery Benefit | |
| vi. | Road Ambulance Cover | |
| vii. | Accidental In-patient Hospitalization (limited to India) | |
| viii. | Transportation of Imported Medicine | |
| ix. | Burns Benefits | |
| x. | Broken Bones Benefit | |
| xi. | Out-patient Expenses | |
| | **Section B: Optional Covers** | |
| I. | Funeral Expenses | |
| ii. | Medical Expenses | |
| iii. | Repatriation of Mortal Remains | |
| iv. | Accidental Hospital Cash | |
| v. | Damage to Personal Protective Equipment | |
| vi. | Coma Benefit | |

| | | |
|---|---|---|
| vii. | Modification Benefit (Residence) | |
| viii. | Modification Benefit (Vehicle) | |
| ix. | Cost of Support Items | |
| x. | Education Fund for Children | |
| xi. | Marriage Fund for Children | |
| xii. | Orphan Benefit for Children | |
| xiii. | Disappearance Benefit | |
| xiv. | Compassionate Visit | |
| xv. | Sports Activity Cover | |
| xvi. | Loss of Job | |
| xvii. | Rehabilitation/ Counselling Benefit | |
| xviii. | Second E-opinion | |
| xix. | Domestic Travel for Medical Treatment | |
| xx. | Chauffeur Benefit (Per day) | |

**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 | | | | | | | |
| | | | | | | Total | |

**9. Details of Documents to be submitted:**

**Documents required for all Benefits**

a) Duly completed personal accident policy claim form signed by Nominee or Insured Person
b) Photo ID of Insured Person & Nominee (where applicable)
c) Claim intimation or claim reference number
d) Attested copies of KYC documents of Insured Person & Nominee (where applicable) - PAN card, ration card, voter ID, etc.
e) Original discharge card / day care summary / transfer summary (where applicable)
f) Attested copy of Medico Legal Certificate copy / First Information Report copy / Panchnama (spot / inquest) where applicable
g) Copies of consultation letters detailing the treatment taken immediately after Accident where applicable.
h) Radiological investigation reports like X ray, CT scan, MRI etc with films supporting the diagnosis of Injury
i) Copies of medical documents towards treatment taken during disability period, including discharge summary of the Hospital where applicable
j) Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details and patient's progress where applicable.
k) In case of employer - employee relationship
   - Employer certificate confirming the employee details, designation and sum insured (In case of unnamed policy)
   - Total Head count of employee – designation or grade wise (In case of unnamed policy)
   - Copy of Company Accident notification register In case the accident has occurred in employer premise (OFFICE / Factory / Plant )
l) Bank account detail form stating bank name, branch name, MICR code, IFSC code, account number and account type - duly signed by Nominee along with personalised cancelled cheque i.e. name of account holder printed on it or copy of 1st page of pass book or bank account statement.

**Documents required in addition for Specific Benefits**

1) Accidental Death
   a) Attested copy of the death certificate issued by Government / Municipal Authorities
   b) Attested copy of cause of death certificate issued by treating Medical Practitioner/ Hospital

c) Copy of burial certificate (wherever applicable)
d) Attested copy of post-mortem Report.
e) Attested copy of viscera report and chemical analysis report
f) Attested copy of witness statement (if available)
g) Hospitalization and treatment Papers (if available)
h) Translation of all vernacular documents in English duly notarized.
i) Salary slip with seal and signature of authorized signatory of the organization (if employed)
j) Last 3 years financial years Income Tax Return for self-employed persons
k) 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) Attested copy of disability certificate issued by Civil Surgeon of District Hospital mentioning the type and percentage of disability.
b) Original 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 slip 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

3) Temporary Total Disablement
a) Attested copy of disability certificate issued by Civil Surgeon of District Hospital mentioning the type and percentage of disability.
b) Original 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 slip 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

4) Recovery Benefit
a) Photocopy of Hospitalization documents: - i.e. discharge card, final Hospital bill, indoor case papers, etc.
b) Any other document as per the check list for Hospitalization / In- patient claims in order to ascertain the genuineness of claim

5) Road Ambulance:
a) Original invoice and paid receipt from the registered Ambulance carrier.

6) Accidental In-patient Hospitalization (limited to India)
a) Original discharge card / day care summary / transfer summary
b) Original final Hospital bill with all original deposit and final payment receipt.
c) Original 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 original diagnostic reports (including imaging and laboratory) along with the Medical Practitioner's prescription and invoice / bill with receipt from diagnostic center.
e) All original medicine / pharmacy bills along with the Medical Practitioner's prescription.
f) Medico legal certificate copy / first information report copy
g) Copy of death summary and death certificate (in death claims only)
h) Pre and post- operative imaging reports – where applicable
i) Copy of the Hospital's registration certificate / copy of Form C in case of Hospitalization.

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

7) Transportation of Imported Medicine
a) Original Treating Medical Practitioner's prescription for use of imported medicine.
b) Original Freight invoice for such imported medicines.
c) Document pertaining to the section under which the benefit is payable i.e. Permanent Total Disablement, Permanent Partial Disablement Benefit, Temporary Total Disablement or Accidental In-patient Hospitalization

8) 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

9) 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 original 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 / nquest)
e) Medical documents / Hospital records evidencing the fracture.

10) Out-patient Expenses
a) Original medicine prescription and advice from treating Medical Practitioner
b) Original invoices, bills, receipts of Medical Practitioner consultations / laboratory reports / radiology investigations / pharmacy bills
c) Original investigation report(s)

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

12) Medical Expenses
a) All documents listed under Accidental In-patient Hospitalization (under Section II.7) and Out-patient Expenses benefit (under Section II.12)

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

14) Hospital Cash:
   a) Photocopy of Hospitalization documents: - i.e. discharge card, final Hospital bill, indoor case papers, etc.
   b) Any other document as per the check list for Hospitalization / In- patient claims in order to ascertain the genuineness of claim

15) Damage to Personal Protective Equipment:
   a) Evidence of Injury due to an Accident
   b) Evidence of damage of equipment mitigating risk to health and safety

16) 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 (original discharge card / day care summary / transfer summary)

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

18) Modification Benefit (Vehicle):
   a) All documents listed under Permanent Total Disablement / Permanent Partial Disablement original 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

19) Cost of Support Items:
   a) Document pertaining to the section under which the benefit is payable i.e. Permanent Total Disablement / Permanent Partial Disablement / Temporary Total Disablement
   b) Prescriptions of treating specialist Medical Practitioner for support items
   c) Original invoice of actual expenses incurred

20) Education Fund for Children
   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

21) Marriage Fund for Children:
   a) Document pertaining to the section under which the benefit is payable i.e. Accidental Death Benefit and Permanent Total Disablement
   b) Proof of relationship of the child with the Insured Person

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

23) Disappearance Benefit
   a) FIR/ Missing complaint
   b) Proof of Accident
   c) Confirmation of death/certificate of death (legal assumption of death) post completion of relevant period applicable under law
   d) Certification of death by the local police authorities (where the Accident took place)
   e) Translation of all vernacular documents in English duly notarized.

24) 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) Original 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)

25) Sports Activity Cover
   a) All documents listed under Accidental Death Benefit & Permanent Total Disablement / Permanent Partial Disablement Benefit

26) Loss of Job:
   a) Document pertaining to the section under which the following benefit is payable i.e. Permanent Total Disablement / Permanent Partial Disablement
   b) Loss of employment/termination letter indicating the reason for termination.
   c) Proof of employment (Appointment letter / Salary slips)

27) Rehabilitation/ Counselling Benefit:
   a) Document pertaining to the section under which the following benefit is payable i.e. Permanent Total Disablement / Permanent Partial Disablement
   b) A certificate from the treating consultant stating;
      a) Indication and advice for rehabilitation and counselling
      b) Medical document evidencing counselling and specialist consultation
      c) Original Invoices & Receipts for the treatment given by such specialist / counsellor.

28) Second E Opinion:
   (a) All documents listed under Permanent Total Disablement & Permanent Partial Disablement Benefit

29) Domestic Travel for Medical Treatment
   a) Document pertaining to the section under which the following benefit is payable i.e. Accidental Death / Permanent Total Disablement / Permanent Partial Disablement
   b) All documents listed under Hospitalization / In- patient claims benefit
   c) Original invoice of the travel expenses incurred
   d) The original ticket / boarding pass indicating the travel dates
   e) Medical Advice / certificate / fitness certificate for travel

f) Prescription from the Medical Practitioner stating the line of medical treatment, the facility where medical treatment needs to be sought and the unavailability of such treatment in the current facility
g) For Accident cases – copy of police report, Injury certificate issued by State Government Undertaking Hospital to assess the severity of disability.

30) Chauffeur Benefit
a) Document pertaining to the section under which the benefit is payable i.e. Permanent Total Disablement / Permanent Partial Disablement Benefit
b) RC book copy of the insured's vehicle
c) Documented evidence of utilization of chauffeur service with bills / receipts

**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 also.]

**11. Details of Nominee**

To be completed by Nominee in the event of Insured Person's death
i. Name of Nominee:
ii. Address:
iii. Date of Birth (DD/MM/YYYY):
iv. Relationship with the deceased:
v. Phone No – Mobile / Home / Work
vi. E-Mail:

**12. Declarations:**

I/We hereby declare and warrant that the foregoing particulars and the information furnished in this claim intimation form are true, accurate and complete in all material respects to the best of my knowledge and belief.
If I have made any false or untrue statement, suppressed or concealed any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent and authorize TPA / 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.

Date: Place: Signature of the Insured Person/ Policyholder/ Nominee

## SECTION B

**To be completed by the Medical Practitioner who originally treated the Injuries**

1. Name and address of the Insured Person:
2. Gender: Male / Female
3. Date of Birth (DD/MM/YYYY) and age:
4. Are you the patient's usual Medical Practitioner? Yes / No
   a) If yes, since when (DD/MM/YYYY)?
   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?
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 (DD/MM/YYYY):
12. If admitted in Hospital: Date of Admission (DD/MM/YYYY): Date of Discharge (DD/MM/YYYY):
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 (DD/MM/YYYY) : To (DD/MM/YYYY) :
    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 (DD/MM/YYYY) :
    c) If No, please state probable date of his/her being able to attend to his/her normal duties (DD/MM/YYYY):
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: Signature of the Medical Practitioner:
Place:
Name & Qualification:
Stamp: Registration Number:

Address:
Telephone No.:
Mobile No.:

**Section C:**
To be filled by employer (in case, Insured Person is employed):

1. Name of the company:
2. Address & contact details of the company:
3. Name of the employee:
4. Date of joining the service:
5. Designation:
6. Please provide details of the leave availed by the employee, specifying the type of leave.

| Sr.No | Date from which leave is taken | Date when resumed duties | No. of Days | Type of Leave | In case of Sickness Leave, medical certificate produced- Yes/ No | Reason for Leave |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Name of the Authorised Person:
Designation:
Date: Place: Signature & Seal:

**Know Your Customer – KYC**
**KYC is required only for Individual/ Retail policy holders if the total claimed amount exceeds 100,000. (AML guidelines are not applicable for Insured Persons covered under Group Personal Accident Policies)**

| GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the hospital) | | |
|---|---|---|
| **DATA ELEMENT** | **DESCRIPTION** | **FORMAT** |
| **SECTION A –** | | |
| **1. DETAILS OF PRIMARY INSURED PERSON** | | |
| a) Policy No. | Enter the Policy number | As allotted by the insurance company |
| b) Name of Primary Insured Person | Enter the Full Name of the Insured Person | 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 Insured Person | Use DD/MM/YYYY format |
| e) Occupation | Indicate Occupation of Insured Person | Please specify the Occupation |
| f)Telephone Number | Enter the Phone Number of Insured Person | Include STD code with telephone number |
| g) Mobile No. | Enter the phone number of Insured Person | Please enter a 10 digit number |
| h) E-mail Address | Enter E-mail Address of Insured Person | Complete E-mail Address |
| i) Employee No | Enter the Employee Number | Please enter the employee Number |
| j) Name of employer | Enter the Name of Employer | Please Enter the Name of Employer |
| k) Name of Entity | Enter the Name of Sub-group/Entity | Please enter the Name of Sub-group/Entity |
| | | |
| a) Name of Claimant | Enter the name of claimant | First Name, Middle Name, Surname |
| b) Relationship with Primary Insured Person | Indicate Relationship of claimant with Insured Person | 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 claimant | Use DD/MM/YYYY format |
| e) Occupation | Indicate Occupation of claimant | Please specify the Occupation |
| f)Telephone Number | Enter the Phone Number of claimant | Include STD code with telephone number |
| g) Mobile No. | Enter the phone number of claimant | Please enter a 10 digit number |
| h) E-mail Address | Enter E-mail Address of claimant | Complete E-mail Address |
| i) 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 Occured | Enter Locality, City, State |

| | | |
|---|---|---|
| c) Whether the Injury is :-<br>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 |

| 11. DETAILS OF NOMINEE |
| --- |
| Nominee to fill in relevant details (Applicable in case of Insured Person's death) |
| **12. DECLARATION** |
| Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. and stamp |