GROUP PERSONAL ACCIDENT CLAIM FORM

FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

FUTURE GENERALI GROUP PERSONAL ACCIDENT - CLAIM FORM

Policy No: _____ **Claim no:** _____
Employee No: _____

1. Details of Insured/ Claimant

Name a) Insured/ Company :_____
b) Claimant:_____

Address :_____
_____
_____ City: _____Pin:_____

Occupation:_____Date of birth:_____ Email ID:_____

Contact No: R: _____Off:_____Mobile:_____

2. Accident Details

Date & Time of accident / Occurrence:_____ Hrs. _____

Place & Location: _____

Description of accident /incidence:_____
_____
_____

3. Details of injuries sustained

In Case of Death:
Details of the Nominee - Name & Address:_____
_____

In Case of Permanent Total Disability:

Specify injured parts of the body:_____

Please specify nature of Disability :_____

4. Has the Police been informed about the accident; If yes please give details

MLC No:_____ FIR No:_____
Name & Address of the Police station: _____

5. Was the injured person under the influence of alcohol/ drugs at the time of accident: YES/ NO

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6. Witnesses

Name (s):_____

Address (s): _____

_____

_____

Contact No: R: _____Off:_____Mobile:_____

7. Treatment Details

Casualty Doctor
Name : _____
Address :_____
Tel no (s) : _____

Family Doctor
Name : _____
Address :_____
Tel no (s) : _____

Hospital Details
Name : _____
Address :_____
Tel no (s) : _____

8. Policy and Claims History

A) Have you made any Claims in Past ? Yes No

B) If YES, Please give details including nature of Accident, Insurance details & Claim amount

C) Are you insured under any other Policy ? Yes No

If YES, Please give full particulars (Name of company , Policy no, Period of insurance, Policy issuing office)

Declaration

I/We agree to provide additional information to the company, if required. I/we the above mentioned, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and if I/we have made, or in any further declaration the company may require in respect of the said accident, shall make any false or fraudulent statement, or suppress or conceal any material fact, the policy shall be void and all rights to recover compensation there under in respect of past, present or future accident shall be forfeited.

Place:_____

Date:_____ **Signature of the insured** **Group/Insured Stamp**

ATTENDING PHYSICIAN'S STATEMENT

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1. Name and Age of insured Person :_____

2. Details of Injuries Sustained:_____

3. Cause of the injury as reported by the injured person:_____
_____

4. Does the Cause of Accident as stated by the Claimant tally with the Injuries noticed by you? : Yes / No : _____

5. Are the injuries solely due to the accident ? : Yes / No_____
If No pls. provide the details

6. Was the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition ? : Yes / No_____

7. Was he/she under the influence of intoxicants or drugs at the time of accident ? Yes/ No :_____

8. What treatment was given and operations performed ? :_____
_____

9. Give all dates of treatment : Clinic/Hospital : From: _____ To: _____
Home: From: _____ To: _____

10. Are you his family doctor ? Yes/ No :_____
If you have treated him for any previous illness or injury :_____
Please give details _____

11. Have other Doctors been in Attendance or Consultation? :_____
If yes, Please give details _____

12.Has this accident been reported to the Police Authorities? If yes please provide
MLC No:_____ FIR No :_____ Police Stn name & Address:_____

13. Nature of injury sufferred by injured person
Fatal:_____ PTD:_____

14. In case of PTD kindly state the % of disability:_____

16. What is the Prognosis? _____

I/We hereby to the best of my/our knowledge and belief, warrant the truth of the above details in every respect.

Doctor's Signature & Stamp:
Doctors Name :
Address and Tel. no Date: Regn No: