## **HDFC ERGO General Insurance Company Limited**



### **GROUP PERSONAL ACCIDENT CLAIM FORM**

Claimant's State	ment	t																																			Fo	rm	'A'
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Insured's Name:																																							
Insured's Address:				Ŧ		F									 	T	T	T										T	T					=	Ŧ	Ŧ	T		
Date of Birth:	D D		ММ		Y	Υ .	Υ			1	Mai	rita	ıl Sta	atus	s:		٨	/lar	ied				Uı	nm	arri	ed													
Phone No. (Off):																Pho	one	No	).(R	es)	):																		
Name and address of employer:		П		Ŧ	<u></u>	F								<u> </u>	<u> </u>	T	T	T										T	T						Ŧ	Ŧ	Ŧ		
Policy Number:				İ	Ī	Ī								I	nsı	ıred	ľs (	Occ	upa	atio	n:								İ		İ	Ī				Ī	İ		
Does the insured have	e any c	other	r insı	ura	nce	?			Ye	es			No	)																									
If yes, please list all co	ompan	ies,	type	of	insu	ura	nce	, p	olic	y n	um	be	rs ar	nd i	nsı	urar	псе	an	nou	nts	:							4	1	Ļ	L	Ļ	Щ	$\perp$	$\perp$	Ţ	Ļ	L	
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Date of accident:	D D	M	M	Y	YY	Y	Υ		Ti	me	ar	nd į	plac	e a	cci	den	t oc	ccu	rrec	d:																Τ	Τ		
Please describe in det	tail the	circ	ums	tar	ıces	of	aco	cide	ent:																										T	T			
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Was the accident relat	ted to	the I	nsur	ed'	's o	ccu	pat	ion	?			Ye	S		1	No		lf s	o, h	OW.	?																I		
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Please describe the na	ature c	of Ins	sure	d's	inju	iries	s:																									L				$\perp$	$\perp$		
Please list the names	and a	ddre	sses	s of	all t	trea	atin	g p	hys	icia	ans	ar	nd ho	osp	ital	s:																L				$\perp$	I		
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Did police or other aut	:horitie	s inv	vesti	gat	e th	е ә	cci	der	nt?			Ye	S		1	No																							
If yes, please provide	name,	, add	Iress	ar	nd te	əler	oho	ne	nur	nbe	er c	of a	ıll inv	ves	tiga	ating	g of	ffice	ers	and	d aç	gen	cie	s:															
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Claimant's Name:				I	$\perp$	I																										I			$\Box$	I	I		
Claimant's Address:				$\perp$																																I			
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Relationship to Insure	d:	Ш	$\perp$	L	Ш	$\Box$								Ag	e:			Yrs						Ph	one	N e	0. (	Off;	: _							$\perp$	L		
Phone No.:				$\perp$		L																																	
In what capacity are y	ou ma	king	this	cla	aim?	?																																	
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AUTHORISATION																																							—
I authorize any insurance or knowledge regarding ERGO General Insurance of this authorization upon valid for the duration of the I understand that any permisleading information or I/We hereby understand Company may be utilise and disseminate the same	the ins ce, or it on requi his clair erson w may be d, decl ed for pr ne to ar	sured ts aut test a m. who k subjet lare, roces	to re thoriz and ag knowi ject to cons ssing	elea zed gre- vingl o pro sent g the	ase a representation ly arrosed t and e cla	any rese at a nd v cuti d a im r	info enta pho with on f utho	inte	atio es, f grap ent nsu e th	n re for to to c ran ne (	eque he p or lefra ce f Con	est pur fac auc frac npa Poli	ed repose csimi d or o ud. any t cy. I/	ega e of ile o dec that We	eva eopy eivo pe	ng the aluaty of the and the a	nis c ting this ny ir nal	plair g an s au nsu hea	n ar d de thor and	nd theter rization	ne le min tion	oss ning n is a par	rep con as v	oort vera alid iles	ed. age d as a c	l ur for the	this e or n co	rsta s cla igin onta	nd t im. al. I inin	his i I kno agr g ar	info ow ee t ny r	rma I hav that mate	tion ve a this erial	n will righ aut ly fa	l be unt to thorial alse,	rece zati inc	d by eive on s omp	HE ac shal	OFC opy I be e or the
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# **HDFC ERGO General Insurance Company Limited**





Accidental Death Claimant's State		Form'E'
	INSURED INFORMATION	
Insured's Name:		
Insured's Address:		
Date of Birth:	DD MM YYYY Marital Status: Married Unmarried	
Phone No. (Off):	Phone No.(Res):	
Name and address		
of last employer:		
Policy Number:	Insured's Occupation(at time of death):	
Did the Insured have a	ny other accident or life insurance? Yes No	
If yes, please list all co	mpanies, policy numbers and insurance amounts:	
	CLAIM INFORMATION	
Date of accident:	D D M M Y Y Y Y Time and place accident occurred:	
Please describe in det	ail the circumstances of accident:	
		(attach separate sheet if needed)
Was the accident relat	ed to the Insured's occupation? Yes No If so, how?	
Please describe the ca	use of the Insured's death:	
Please list the names	and addresses of all treating physicians and hospitals:	
Bil ii ii ii		
Did police or other aut	norities investigate the accident? Yes No	
If yes, please provide	name, address and telephone number of all investigating officers and agencies:	
Was an autopsy perfor	med? Yes No If yes, please provide name and address of Medical B	=xaminer:
Was a coroner's inque	st held? Yes No If yes, what was the determination?	
	CLAIMANT INFORMATION	
Claimant's Name:		
Age: Yrs	Relationship to Insured:	
Claimant's Address:		
Dhara Na (Off)	Diama Na (Dan)	
Phone No. (Off):	Phone No.(Res):	
In what capacity are yo	u making this claim? Beneficiary Executor* Administrator*	Guardian* Trustee* Assignee*
insurance company, phy regarding the insured to General Insurance, or its authorization upon reque the duration of this clair materially false, incomple I/We hereby understand Company may be utilised	ed copy of all documents supporting your authority (e.g., Succession Certificate, Notarises sician, hospital or other healthcare provider, or any other organization, institution or person the release any information requested regarding this claim and the loss reported. I understand authorized representatives, for the purpose of evaluating and determining coverage for this clast and agree that a photographic or facsimile copy of this authorization is as valid as the origina. I understand that any person who knowingly and with intent to defraud or deceive any insteading information may be subject to prosecution for insurance fraud.  If declare, consent and authorise the Company that personal health details, medical histor for processing the claim made under the Policy. I/We hereby also understand, declare and coe to any service provider for providing services related to insurance.	nat may have records, documents or knowledge of this information will be used by HDFC ERGO aim. I know I have a right to receive a copy of this al. I agree that this authorization shall be valid for asurance company files a claim containing any y and financial information, as provided to the
Date: DDMMM	Y	SIGNED(Claimant or authorized person)

### **HDFC ERGO General Insurance Company Limited**



Date: DD MM YYYY

### **Consent for Mode of Claim Payment**

Signature of Beneficiary

Stamp Required in case of Company

Name of Insured	
Policy Number	
Claim Number	
Beneficiary Name	
Mode of Payment Cheque Fund Transfer (Please tick for mode of payment)	
(All Fields are Mandatory in case of Fund Transfer)	
Insured's Name as per Bank Account	
Bank Account Number	
Branch Name	
IFSC Code Email address Email address	
Attachments In Support of Bank Details (Please tick the type of proof submitted)  Cancelled Cheque Bank Passbook Copy	
Declaration: I Mr./ Mrs/ Msundersigned, legal beneficiary of the above claim, declare that all details mentioned in this form are true and I agree to the mode of payments.	 ent
against the particular claim number mentioned above.	