HDFC ERGO General Insurance Company Limited

GROUP PERSONAL ACCIDENT CLAIM FORM

Claimant's Statement — Form'A'

INSURED INFORMATION

Insured's Name:

Insured's Address:

Date of Birth: D D M M Y Y Y Y Marital Status: ☐ Married ☐ Unmarried

Phone No. (Off): Phone No.(Res):

Name and address of employer:

Policy Number: Insured's Occupation:

Does the insured have any other insurance? ☐ Yes ☐ No

If yes, please list all companies, type of insurance, 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 detail the circumstances of accident:

(attach separate sheet if needed)

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

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:

Claimant's Address:

Relationship to Insured: Age: Yrs Phone No. (Off):

Phone No.:

In what capacity are you making this claim?

AUTHORISATION

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.

I/We 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. I/We hereby 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.

Date: D D M M Y Y Y Y

SIGNED (Claimant or authorized person)

HDFC ERGO General Insurance Company Limited

ACCIDENTAL INJURY - CLAIM FORM

Accidental Death
Claimant's Statement

Form'E'

INSURED INFORMATION

Insured's Name:

Insured's Address:

Date of Birth: D D M M Y Y Y Y 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 any other accident or life insurance? ☐ Yes ☐ No

If yes, please list all companies, 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 detail the circumstances of accident:

(attach separate sheet if needed)

Was the accident related to the Insured's occupation? ☐ Yes ☐ No If so, how?

Please describe the cause of the Insured's death:

Please list the names and addresses of all treating physicians and hospitals:

Did police or other authorities investigate the accident? ☐ Yes ☐ No

If yes, please provide name, address and telephone number of all investigating officers and agencies:

Was an autopsy performed? ☐ Yes ☐ No If yes, please provide name and address of Medical Examiner:

Was a coroner's inquest held? ☐ Yes ☐ No If yes, what was the determination?

CLAIMANT INFORMATION

Claimant's Name:

Age: Yrs Relationship to Insured:

Claimant's Address:

Phone No. (Off): Phone No.(Res):

In what capacity are you making this claim? ☐ Beneficiary ☐ Executor* ☐ Administrator* ☐ Guardian* ☐ Trustee* ☐ Assignee*

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*Please provide a certified copy of all documents supporting your authority (e.g., Succession Certificate, Notarised Affidavit, Notarised will, etc.)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.

I/We 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. I/We hereby 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.

Date: D D M M Y Y Y Y

Place:

SIGNED(Claimant or authorized person)

HDFC ERGO General Insurance Company Limited

Consent for Mode of Claim Payment

Name of Insured

Policy Number

Claim Number

Beneficiary Name

Mode of Payment (Please tick for mode of payment) Cheque ☐ Fund Transfer ☐

(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

Attachments
In Support of Bank Details
(Please tick the type of proof submitted) Cancelled Cheque ☐ Bank Passbook Copy ☐

Declaration: I Mr./ Mrs/ Ms. _____ 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 number mentioned above.

Signature of Beneficiary
Stamp Required in case of Company

Date: D D M M Y Y Y Y