Maharaksha Claim Form

Claim Form

TATA AIG INSURANCE
WITH YOU ALWAYS

IMPORTANT:

1. Issuance of this form is not an admission of Liability or a waiver of the terms, conditions and exceptions of the insurance contract.
2. No claim will be admitted without a Medical Report (Attending Physician's Statement) as per format (Page 4) to be obtained at claimant's expense.

Claim No. _____ **Policy No.** _____

PERSONAL DETAILS

Name a) Insured _____

b) Claimant _____

First Name Middle Name Surname

Address _____

City _____

State _____ PIN _____

Phone (O) _____ (R) _____

Fax _____ Mobile _____

E-mail _____

Date of Birth D D M M Y Y Y Y Occupation _____

(Please be available at this place where our representative may call on you)

2. ACCIDENT DETAILS

Time and Date _____ D D M M Y Y Y Y

Place and Location (full address) _____

Cause Description _____

3. INJURIES/CLAIM DETAILS

A. Fractures/Dislocation/Burns

Part of Body which is Injured:

Hip or Pelvis ☐	Thigh or Heel ☐	Lower Leg ☐	Skull ☐
Clavicle ☐	Ankle ☐	Elbow/s ☐	Arm (upper) ☐
Arm (Lower) ☐	Shoulder Blade ☐	Knee cap ☐	Sternum ☐
Hand ☐	Foot ☐	Spine ☐	Lower Jaw ☐
Rib/s ☐	Cheekbone ☐	Coccyx ☐	Upper Jaw ☐
Nose ☐	Toe/s ☐	Finger/s ☐	_____ ☐

Type of Injury:

Compound Fracture ☐	Complete Fracture ☐	Colles Fracture ☐
Compression Fracture ☐	Pedicle Fracture (Transverse & Spinous) ☐	Neurological damage (due to fracture) ☐
Other Vertebral Fractures ☐	2nd Degree Burns ☐	3rd Degree Burns ☐
Dislocations ☐	Internal Injury resulting in abdominal or thoracic surgery ☐	

B. In-Hospital Indemnity - Accident Only

Details of Accident:

Type of Injury: _____ Name of Hospital _____

Address: _____

Phone Nos.: _____ Attending Doctor: _____

Date of Admission: _____ Date of Discharge: _____

C. Loss of Activities of Daily Living

Date when activities ceased _____/_____/_____ When activities Resumed _____/_____/_____

Please list the Activities you were unable to perform during your period of confinement:

D. Accidental Death

Time and Date D D M M Y Y Y Y

Cause of death

4. TREATMENT DETAILS

A. Name of Casualty Doctor

Address

Phone

Registration No

B. Name of Family Doctor

Address

Phone

Registration No.

C. Name of Hospital(s)

Address

Phone No

6 PAST HISTORY

A Have you preferred any accident claims in the PAST? YES NO

B If YES, please give details including accident and Insurance details

7. Are you insured under any other policy ? YES NO

If YES, please give full details

8. Have the Police Authorities been informed of this accident? YES NO

If YES, Case No _____ Police Station _____

9. Name of WITNESS

Address

Phone No

I hereby declare that I have suffered injuries as described above and all the details given are ABSOLUTELY TRUE AND CORRECT. I hereby agree to forfeit all my rights to compensation if any of the foregoing facts and/or details are found to be false or incorrect. I further authorise the hospital, doctor diagnostic laboratory, organisation, establishment or any other body or person dealt with in the course of this claim to give any information or document sought for by the Insurance Company.

Date: _____

Place: _____

_____

Signature of the Insured

ATTENDING PHYSICIAN'S STATEMENT

PLEASE ANSWER ALL QUESTIONS

1 Name of Injured Person:

2 Age

3 Address

4 **Details of Injury: Fractures/Burns/Dislocation**

A. Nature of the Accident

B. Part of Body which is Injured:

Hip or Pelvis	☐	Thigh or Heel	☐	Lower Leg	☐	Skull	☐
Clavicle	☐	Ankle	☐	Elbow/s	☐	Arm (upper)	☐
Arm (Lower)	☐	Shoulder Blade	☐	Knee cap	☐	Sternum	☐
Hand	☐	Foot	☐	Spine	☐	Lower Jaw	☐
Rib/s	☐	Cheekbone	☐	Coccyx	☐	Upper Jaw	☐
Nose	☐	Toe/s	☐	Finger/s	☐	_____	☐

C. Type of injury: (please specify type of fracture, Degree of burns etc.)

_____

_____

5. Does the Cause of Accident as stated by the Claimant tally with the Injuries noticed by you?

_____

_____

6. Are the injuries solely due to the accident or traceable to any previous injuries/disease/infirmities ?

_____

_____

7. Was the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition.

_____

8. Was the Claimant hospitalized? If so for what period? _____

9. What treatment was given and Operations performed? _____

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

Home: From _____ To _____

11. Was he under the influence of intoxicants or drugs at the time of accident ? _____

12. Are you his usual medical Attendant ?

If you have treated him for any previous illness or injury, Please give details.

_____

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

_____

14. Has this accident been reported to the Police Authorities? If yes, Case No: _____ Police Station _____

15. Is this claimant Disabled from performing any of the following activities:

Mobility ☐ Continence ☐ Dressing ☐ Toileting ☐ Eating ☐

16. How long was or will the claimant be totally disabled? From _____ To _____

17. What is the Prognosis? _____

Doctor's Signature _____

Date: _____

Regn No: _____

Qualifications: _____

Doctors Name: _____

Address: _____

Phone No. _____