CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED
Registered and Head Office: 2nd Floor, Dare House, 234, N.S.C. Bose Road, Chennai 600 001
customercare@cholamandalam.co.in; Toll free help line 1600 44 5544; www.cholainsurance.com

Cholamandalam
ENTER A BETTER LIFE

CHOLA ACCIDENT PROTECTION – CLAIM FORM

Policy No. _____

1. **Proposer Information:**
   Name of Insured _____
   Address of communication: _____
   City:/ Pin code / State/ Tel No. / Fax No. / Mobile
   Occupation _____
2. **Details of the Injured Person in respect of whom the claim is made:**
   Name: _____
   Relationship with insured: _____
   Date of Birth: __. __. ____
3. **Policy section relating to claim (Tick)**
   - ❑ Accidental death
   - ❑ PTD
   - ❑ PPD
   - ❑ WI
   - ❑ Broken Bones
   - ❑ Modification of Residence/vehicle
   - ❑ Cost of transporting Mortal remains
   - ❑ Cost of performing death ceremony
   - ❑ Ambulance Hiring Charge
   - ❑ Hospital Daily cash
   - ❑ Family Transportation Benefit
   - ❑ Child's Fee for Private Tuition
4. **Details of Accident:**
   a. Date of Accident: __.__.____
   b. Time of Accident: _____
   c. Place of Accident _____
5. **Name and Address of Hospital/Nursing home where the injured is treated**
   _____
6. **Brief description of the accident:** _____
7. **Nature of Accident** _____
8. **Have the police been informed about the accident** Yes: ____ No: **____**
   If yes, please give details : FIR No. _____ Name of Police Station _____
9. **Was the injured person under the influence of liquor/drugs at time of accident Yes No**
10. **Witness of accident**
    Name and contact details including Phone number
    a) _____
    b) _____
11. **Where the Injured person can be contacted**_____
12. **Disability type and period** _____
    a. Death
       Details of the nominee / assignee
       Name:
       Address:
    b. Permanent Total Disablement:
       Nature____Percentage _____
    c. PPD:
       Nature____Percentage _____
    d. WI
       No. of days_____
       Date of Accident_____
       Date of fitness: (Attach Dr. Certificate)_____
       Date of resuming duties:_____
    e. HDC
       No. of days of Hospitalisation:
       Please furnish proof of Hospitalisation like Discharge Summary from the Hospital
    f. Child's Fee for Private Tuition
       No. of days for which the insured couldn't attend the Educational Institution:

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Please furnish a letter duly signed and stamped by the Principal or competent authority of the Educational Institution mentioning the number of days insured missed the Educational Institution along with the Medical Certificate and other supporting documents.

g. Any other benefit
    1. _____
    2. _____
    3. _____

Declaration

(To be given by the Claimant)

I hereby to the best of my knowledge and belief, warrant the truth of the above details in every respect. I agree that if we have made already or if I make in any of my further statements in respect of the said incident or any false or fraudulent declarations or suppress or conceal any material fact, the Policy shall be void and all rights of compensation in respect the present or future claim shall be forfeited.

Place: _____
Date: __.__.____ Signature of Claimant / Insured

MEDICAL REPORT

(To be filled by treating Doctor)

1. Name of the Injured Person: _____
2. Are you his/her usual medical attendant? Yes ____ No ____
3. Details of Injuries sustained: _____
4. Cause of Injuries sustained: _____
5. Does nature of injury sustained corresponds to the cause? Yes ____No ____ if No, provide details
6. Are the injuries suffered solely due to accident Yes ____No ____ if No, provide details
7. Was the injured person under influence of Liquor/drugs at the time of accident? Yes ____ No ____
8. What was the treatment administered?
9. How many days was the injured person in hospital?
10. Details & dates of treatment
    Date and time of admission in the Hospital:
    Date and time of discharge from the Hospital:
    Home From: To:
11. Nature of injury suffered with the insured/injured person
    a. Fatal
    b. PTD
    c. PPD
    d. TTD
12. Incase of PTD/PPD – kindly state the % of disability
13. in you opinion when will the insured/injured person will be able to resume duties?

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

Place: _____ *Date:* __.__.____

Signature and Stamp

Name of Doctor: _____ *Registration No.:* _____

Address.: _____