bharti AXA

redefining / general insurance

Bharti AXA General Insurance Company Limited

1800-103-2292 (Toll Free)
claims@bharti-axagi.co.in
SMS <CLAIM> to 5667700
www.bharti-axagi.co.in

Smart*Individual* Personal Accident Insurance - Claim Form

Important Note

Issuance of this form not to be taken as an admission of liability

Please fill this form in **Block Letters** and **Tick the Boxes** ☑ where appropriate and do not leave any column unanswered.

Part - I

Policy Number: Claim Number:

1 Insured Details

Name of the Insured:

Address

City

Pin code State

Mobile No. E-mail ID

2 Claim Details

Date of Accident D D M M Y Y Y Y Time of Accident H H M M (Kindly provide exact location of accident)

Place of Accident

Description of Accident:

Kindly provide us with the present contact details where our representatives/Doctor could examine the injured. (applicable only in injury cases)

Please indicate whether claim is in respect of (tick boxes)

☐ Temporary Total Disability ☐ Total Permanent Disability ☐ Accidental Death ☐ Medical expenses only

Was the injury sustained during work hours? ☐ Yes ☐ No

Are you currently insured under any other accident insurance policies? ☐ Yes ☐ No
If yes, kindly complete the following table.

Sl. No.	Name of Insurance Company	Policy No.	Commencement Date	Sum Insured (Rs.)

3 Documents Required for Claim Settlement

Below is a list of minimum documentation required to process your claim. In certain circumstances, additional information may be required in order for further confirmation. (Please tick against the documents you have submitted)

- ☐ Copy of First Prescription
- ☐ Medical Certificates
- ☐ Original Final Hospital/ Medical Bills
- ☐ Medical Reports/ Inpatient Discharge Summary
- ☐ Police Report/ Accident Report – for road accident claim, etc.
- ☐ Death Certificate and Post Mortem Report – only for death claim.

4 Bank Details of the Insured (In case of any dues from the company, the amount will be credited to this bank account)

Name (as per bank account)

Bank Name

Account Number

IFSC Code

Branch Name

(Kindly attach cancelled copy of cheque. If name of A/C holder not printed on cheque then additionally attach copy of passbook)

5 Insured's / patient's consent for access to medical records & declaration

I/We hereby authorize Bharti AXA General Insurance Co. Ltd. or any other individual/agency engaged by Bharti AXA to obtain all medical records pertaining to the above patient available with any hospital/doctor. The Insurance Company or their representatives or any other authorised agency engaged by them may be allowed access & possession of medical records pertaining to the above patient. The necessary charges will be borne by the Insurance Co. or their authorised agencies.

I/We agree to provide additional information to the Company, if required. I/We the abovenamed, 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 any suppression or concealment, the policy shall be void and all rights to recover thereunder in respect of past or future claims shall be forfeited.

Data Privacy Notice:

I/We hereby provide consent to the Company for collecting/retaining any information relating to Me/Us including Sensitive Personal Information ("hereinafter cumulatively referred to as "INFORMATION"), that is either available with the Company or disclosed by Me/Us while obtaining the policy of Insurance from the company or otherwise. I/We further understand that the Company may use the INFORMATION for servicing the Insurance policy obtained by Me/Us and for same may share the INFORMATION with any reinsurer, insurance association, medical authorities, other Insurers, statutory authorities, court, governmental body, regulator etc., or with services provider(s) engaged by the Company for servicing the Insurance policy, underwriting the risk, settlement of claim etc. without obtaining our specific consent for such sharing and we hereby provide our consent to Company for same.

I/We understand that whenever I/We would like to update/correct the INFORMATION, we will intimate the Company for the same, so as to enable the Company to amend/correct the INFORMATION accordingly. Further in the event I/We would like to withdraw My/Our consent provided herein, I/We would intimate the Company of the same in writing and also understand that, in the event of such withdrawal by Me/Us, the Company reserves the right to not provide Me/Us the Services for which it has sought the INFORMATION.

Date: _____ Name: _____

Place: _____ _____

Signature of the policy holder/Claimant

6 Track your claim status

Once your claim is registered, you will be updated through email. If you have any query on your claim, please reach us on:

Bharti AXA General Insurance is committed to making your personal accident claim process as easy and stress-free as possible. Thank you for insuring with us. We are always glad to be of service.

CF/IPA/THINQ/08-15

Insurance is the subject matter of solicitation.

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Part - II: Attending physician's statement

Name of the Injured/Deceased

Age Years Gender: Male Female

Address

City

Pin code State

Date when injured was brought to you first: D D M M Y Y Y Y

Diagnosis:

Please provide previous medical history of the injured:

Is the present condition/disability attributable to conginetal defect? If yes, please provide details:

Nature of the accident and details of injuries sustained:

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

Nature of treatment/surgery performed for present illness/disease/injury:

Was injured/deceased under the influence of intoxicants or drugs at the time of accident?
If yes, please provide details of diagnosis done and alcohol content.

Are you his/her usual medical attendant? If yes, please give detailsof previous treatment for any illness/disease/injury:

Attending Doctor's Name

Registration No.

Address

City

Pin code State

Telephone No.

Date:

Doctor's Signature

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