Claim Form for Personal Accident Insurance

(To be filled in by the Insured Policyholder or Insured's Representative duly authorized by Power of Attorney. Issuance of this claim form is not to be taken as an admission of liability. Please attach all bills, receipts, credit card slips pertaining to your claim)

Policy/Certificate No. _____ Policy Period: From_____ To_____

1. **Details of Policyholder**

i. Name: _____

ii. Address: _____

iii. Phone No: _____

iv. Email ID: _____

v. Relationship with policyholder: _____

Details of Claimant (If different than policyholder)

vi. Name: _____

vii. Address: _____

viii. Phone No: _____

ix. Email ID: _____

x. Relationship with policyholder: _____

2. **Select the benefits for which claim is being made (Tick against the benefit(s))**

	Accidental Death Benefit		Coma Benefit or Comatose		Spouse Care Benefit
	Permanent Total Disability Benefit		Animal Attack Cover		Compassionate Visit Benefit OR Family Transportation
	Permanent Partial Disability Benefit		Rehabilitation Cover		Medical Insurance Premium Cover
	Temporary Total Disability Benefit		Reconstructive surgery Cover		Parental Care Benefit or Elderly Care
	Accidental Hospitalization		Accidental Miscarriage Benefit		Family Counselling Benefit
	Serious Illness Benefit		Domestic Travel for Medical Treatment Cover		Loss of Personal Material Cover
	Out-patient Expense Cover or Accidental OPD		Repatriation Cover or Transportation of Mortal Remains		On Duty Cover
	Physiotherapy Cover		Funeral Benefit OR Last Rites		Common Carrier Benefit
	Transportation of Imported Medicine Cover		Modification made at home/ Vehicle or Residential Accommodation and Vehicle Modification Allowance		Terrorism Cover
	Purchase of Blood Cover		Personal liability		Common Accident Benefit
	Prosthesis Device Cover or Prosthetics/Wheel Chair		Emergency Hotel Requirement Cover		Adventure Sport Cover
	Hospital Daily Cash Benefit		Home Convalescence Cover		Head & Spinal Injury Benefit
	Road Ambulance Cover		Loss of Activities of Daily Living Benefit		Loan Protect Benefit
	Air Ambulance Cover		Monthly Needs Benefit		Fixed Medical Expenses

	Second Medical Opinion Benefit		Education for Dependent Children Benefit		Variable Medical Expenses
	Burns Benefit		Marriage Fund for Children Benefit		Child Support
	Broken Bones Benefit		Orphan Benefit		Accident Care

3. Details of Accident

i. Date of Accident:

_____

ii. Time of Accident: _____

iii. Cause of Accident: _____

iv. Details of accident: _____

_____

v. Place/address of Accident: _____

_____

vi. In case of death, please mention date of death _____

4. Details of witness

i. Was there any witness to the Accident/Incidence? (If 'Yes', provide details)

_____

ii. Name of witness: _____

iii. Address of witness: _____

iv. Contact details of witness: _____

v. Is Witness relative of Claimant? _____

5. Police report details

i. Has the loss been reported to Police Authority? _____

ii. If 'No', reason for not reporting: _____

_____

iii. First Information Report (FIR) No. _____

iv. Medico Legal Case (MLC) No. _____

v. Report Date _____

vi. Address of Police Station _____

6. Hospitalization details

i. Was the person moved to hospital immediately after the accident? _____

ii. Name of Hospital: _____

iii. Address of Hospital: _____

iv. Contact Details: _____

v. Date of Admission: _____

vi. Date of Discharge: _____

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

_____

7. Treatment Details

i. Name of Causality doctor: _____

ii. Address of Causality doctor: _____

iii. Phone No. of Causality doctor: _____

iv. Registration No. of Causality doctor: _____

v. Name of Family doctor: _____

vi. Address of Family doctor: _____

vii. Phone No. of Family doctor: _____

viii. Registration No. of Family doctor: _____

8. Confinement Details

i. Total confinement: From - _____ To - _____

ii. Partial confinement: From - _____ To - _____

9. Amount of Claim

i. Total Temporary Disability: Amount (Rs) _____

ii. Permanent Disability: Amount (Rs) _____

iii. Medical Expenses: Amount (Rs) _____

iv. Death: Amount (Rs) _____

10. Past History Details

i. Have you have any claims in the past with us? _____

ii. If yes, please give please give details including accident and Insurance details: _____

_____

11. Details of other insurance

i. Is the Accident/Incidence covered under any other Insurance? _____

ii. If Yes, Name of Insurance Company: _____

iii. Policy No: _____

iv. Sum insured: _____

v. Policy period from: _____ To: _____

12. Payee Details

i. Bank name: _____

ii. Branch name: _____

iii. Bank account No: _____

iv. IFSC code: _____

v. MICR No: _____

vi. PAN No: _____

Note: It is agreed that the Policyholder/Claimant will intimate in writing to Niva Bupa Health Insurance about any change in bank account details. Please attach a cancelled cheque pertaining to the same account.

13. Any other information you wish to provide

_____

_____

_____

_____

I/We, the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect; and I/We agree that if I/We have made, or make in any further declaration, the Company may require in respect of the said accident, any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited.

Place: _____

Name: _____

Date: _____

Signature: _____

14. MEDICAL CERTIFICATE - To Be Filled By Treating Doctor

Name and address of insured: _____

_____

Gender: _____ Date of Birth: _____

Phone No. of the insured: _____

Details of accident: _____

_____

Cause of accident: _____

Are the injuries solely due to accident? _____

Was the claimant Hospitalized? If so for what period? _____

Are you his usual medical attendant? If you have treated him for any previous illness or injury, please give details: _____

_____

Have other doctors been in attendance or consultation? If yes, please give details_____

_____

Has this accident been reported to police authorities? If yes, Case no: _____

Name and address of police station: _____

Are the injuries traceable to any disease? If yes, provide details. _____

_____

Are the injuries traceable to previous injuries? If yes, provide details. _____

_____

Was insured under influence of drugs/alcohol/intoxicants at the time of accident? _____ Was the accident due to Pregnancy? _____

Is the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his/her condition or delay improvement? If yes, provide details.

_____

_____Details of disablement: _____

Details of treatment: _____

According to you, how long should the injured person be confined to bed/house as the direct and sole consequence of the injury sustained? _____

During this period will the injured person be able to attend to his/her normal duties? _____

_____

If yes, from _____

If 'No', please state probable date of his / her being able to attend to his normal duties ____

_____

Is this claimant totally disabled from each and every occupation?_____

What is the prognosis? _____

_____

I certify that I have examined the above named Insured, the above statements are correct. Name of Attending Physician: _____

Qualification: _____

Registration No: _____

Address: _____

_____

Phone: _____

Date_____ Place_____ Signature of attending physician with stamp

Stamp of hospital