Magma HDI General Insurance Company Limited
**Regd. Office :** 24 Park Street, Kolkata – 700 016
P : + 91 033 - 4401 7304 / 7477, F : 91 033 - 4401 7471

**Toll Free No. 1800 266 3202**

# CLAIM FORM

# INDIVIDUAL PERSONAL ACCIDENT INSURANCE

**Magma HDI General Insurance Company Limited**
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# Claim Form

# Individual Personal Accident Insurance

Claim No._____

*All questions must be answered fully. If there is insufficient space, kindly use a separate sheet which can be attached to this form. If any section is not fully completed or left blank, the form will be returned for completion.*

*The issue or acceptance of this form is not to be construed as an admission of liability by MHDI.*

**A. The Insured**

Name _____

Address_____

_____

Tel No. Office_____ Mobile_____ email _____



**B. Policy Details**

Policy No._____Period of Insurance _____ to _____

**C. Claimant/Deceased Details**

Name _____

Sex Male □ Female □

Date of Birth _____/_____/_____

Occupation_____

Relationship with Insured_____

Address where a representative on behalf of **MAGMA HDI GENERAL INSURANCE COMPANY LIMITED** can visit _____

_____ _____

## D. Accident Details

Date of accident (dd/mm/yy)_____/_____/_____
Time of accident _____ am/pm

Did it occur at work **Yes** ☐ **No** ☐

Where did the accident occur_____

How did the accident happen

_____

_____

_____

Was the accident reported to Police **Yes** ☐ **No** ☐
If not, kindly state the reasons

_____

_____

Are there any witnesses to the accident **Yes** ☐ **No** ☐
If yes, kindly provide name(s) and contact details

_____

_____

Was Post-mortem conducted **Yes** ☐ **No** ☐
If yes, kindly attach a copy of the Report

Describe the nature of injuries received

_____

_____

Period of disability

Total disability-confined to Bed
(dd/mm/yy)_____/_____/_____ to_____/_____/_____

Partial disability – confined to House
(dd/mm/yy)_____/_____/_____to_____/_____/_____

If partially disabled, kindly state the daily duties of usual occupation which cannot be performed_____

**E. Hospitalization / Treatment Details**

Name & contact details of doctor first consulted after the accident_____ ___
_____
_____

Name and contact details of other doctors consulted _____
_____
_____

Name and contact details of claimant's usual medical practitioner
_____
_____

Whether hospitalized following the accident **Yes** □ **No** □

If yes, name & address of hospital
_____

Period of hospitalization
(dd/mm/yy)_____/_____/_____ to_____/_____/_____



**F. Other Insurances**

Details of any other insurance (arranged by self, spouse, parents or employer) under which claimant/deceased is covered

| Name of insurer | Policy Number | Period of insurance | Coverage | Sum insured |
|---|---|---|---|---|
| | | | | |
| | | | | |

**G. Claim Amount**

I hereby warrant the truth of foregoing statement and sincerely declare that I have not suppressed or concealed any information that is material to this claim. I understand that false declarations may result in **MAGMA HDI GENERAL INSURANCE COMPANY LIMITED** being able to refuse to pay a claim.

I authorize any hospital, physician or any other medical provider who has attended me or examined me to furnish **MAGMA HDI GENERAL INSURANCE COMPANY LIMITED** such details of my medical history/treatment as they may require.

Signature of Insured/claimant

Date

**Documents to be attached to the claim form:**

- 
- 

**Medical Attendant's Certificate**

Name of patient _____

Occupation_____

How long have you known this patient _____

Are you his/her usual Medical Attendant **Yes** □ **No** □

Kindly state the nature of and extent of injuries

_____

_____

Is the injury consistent with patient's description of the accident **Yes** □ **No** □

Are the injuries connected with any previous accident, infirmity or disease **Yes** □ **No** □
If yes, please provide details _____

_____

_____

Will the recovery be retarded due to above **Yes** □ **No** □
If yes, kindly provide details

_____

When were you first consulted for this injury/disability (dd/mm/yy)_____/_____/_____

Please give details of other consultations – Doctor's name _____
address_____

_____

Are you still treating the patient for the injury/disability **Yes** □ **No** □

Kindly provide details of treatment prescribed

_____

_____

If X-ray has been done, kindly state the findings and Radiologist's report

_____

_____

If hospitalized, name of hospital _____

_____

Period of hospitalization (dd/mm/yy) _____/_____/_____ to_____/_____/_____

Date & Nature of surgical procedure, if any (dd/mm/yy)_____/_____/_____.

_____

Are there any complications which may retard the recovery: _____
_____

Has the patient suffered from similar injury/disability previously? **Yes** □ **No** □
If yes, when, nature and duration of the
_____
_____

Was the patient under the influence of intoxicants or drugs at the time of accident?

**Yes** □ **No** □

While under your care and direction, how long was or will the patient be:

a) Totally unable to perform each and every duty of his/her usual occupation
From (dd/mm/yy)_____/_____/_____ to_____/_____/_____

b) Partially disabled from performing his/her usual occupation
(dd/mm/yy)_____/_____/_____ to_____/_____/_____

Nature of disablement (in case of permanent disability)

Permanent Total Disability
_____

Permanent Partial disability
_____



Prognosis Please comment on any additional factor that may prolong recovery from injury/disability _____
_____

I certify that I have personally attended to the named above patient and the above statements are correct.

Signature* Qualification Reg.No.

Name: Address

Date

*Kindly Affix official seal/stamp

*******