Accidental Injury Claim
Claimant's Statement

Form 'A'

INSURED INFORMATION

Insured's Name_____ **Date of Birth** ___/____/____ **Marital Status** ____

Insured's Address _____ **Phone No. (Off)**_____

_____ **Phone No. (Res)**_____

Name and address of employer _____

Policy Number _____ **Insured's Occupation** _____

Does the insured have any other insurance ? _____**If yes, please list all companies, type of insurance, policy numbers and insurance amounts:**_____

_____

CLAIM INFORMATION

Date of accident _____/_____/_____ **Time and place accident occurred**_____

Please describe in detail the circumstances of accident (attach separate sheet if needed): _____

_____

Was the accident related to the Insured's occupation? _____ **If so, how?** _____

Please describe the nature of Insured's injuries:_____

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

_____

_____

Did police or other authorities investigate the accident? ____ **If yes, please provide name, address and telephone number of all investigating officers and agencies:** _____

CLAIMANT INFORMATION (If different than "Insured Information" above)

Claimant's Name_____ **Age**_____ **Relationship to Insured**_____

Claimant's Address_____ **Phone No. (Off)** _____

_____ **Phone No. (Res)**_____

In what capacity are you making this claim? _____

AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by HDFC ERGO General Insurance, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Claimant or authorized person) _____ **DATE** ____/____/____