ACCIDENT SURAKSHA CLAIM FORM

FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

Note: The claim form is to be duly filled and signed by the insured. All facts and statements must be factual not influenced or biased in any favour.

Policy Number | | | | | | | | |

INSURED DETAILS

1. **Name of the Insured (in full):**

2. **Address of the Proposer:**

State	**Pin code**
Mobile	**Landline**
Email	

***Please note that claim cheque (if any) will be dispatched to the address mentioned above. This address will be updated in above mentioned policy.**

3. **Bank Details:**

Bank Name	
Branch	
Type of A/c	**A/c no**
Pan No	
IFSC Code	**MICR code**

DETAILS OF ACCIDENT

4. **Date and time of Accident:** D D M M Y Y H H M M **AM/ PM**

5. **Please state the place of Accident**
_____

6. **Please provide brief details of accident/ incidence**
_____

DETAILS OF INJURIES SUSTAINED

7. **Please specify the section under which the claim is lodged**

Primary Covers		**Additional Covers**
☐ Accidental Death	☐ Child Education Support	☐ Loan Protector
☐ Permanent Total Disablement	☐ Life Support Benefit	☐ Repatriation Benefit and Funeral Expenses
☐ Permanent Partial Disablement	☐ Accidental Medical expenses	☐ Adaptation Allowance
☐ Temporary Total Disablement	☐ Accidental Hospitalisation	☐ Family Transportation Allowance
	☐ Hospital Cash Allowance	

8. **In Case of Death: Please provide following details:**
   a. **Name of Nominee:** _____
   b. **Address of Nominee:** _____
   _____

9. **Specify injured parts of the body:**_____

10. **Please specify nature of Disability:**_____

11. **In case of Permanent Partial Disablement: Please mention disability percentage**
    Percentage: _____ **(%)** _____**(In words)**

12. **In case of Confinement/ Away from work: Please mention the period of confinement (This should be the actual days when fully confined to bed on Medical Advise)**
    Total Confinement: From _____**To**_____
    Partial Confinement: From _____**To**_____

13. **Have the Police been informed about the accident? ☐ YES ☐ NO**
    If YES, please give following details
    MLC No: _____**FIR No:** _____
    Name & Address of the Police station: _____

14. **Was the injured person under the influence of alcohol/ drugs at the time of accident? ☐ YES ☐ NO**

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15. Please provide details of medical expense (if covered):

Date	Receipt No.	Particulars	Amount

Please attach separate sheet for additional bills / receipt details

16. Please provide following details of Witnesses

Name: _____

Address: _____

_____

Contact No: _____

Name: _____

Address: _____

_____

Contact No: _____

17. Please provide following details

CASUALTY DOCTOR

Name: _____

Address: _____

_____

Contact No: _____

FAMILY DOCTOR

Name: _____

Address: _____

_____

Contact No: _____

HOSPITAL DETAILS

Name: _____

Address: _____

_____

Contact No: _____

DETAIL OF OTHER INSURANCES

18. Are you insured under any other Policy? ☐ YES ☐ NO. If YES, Please give following details

Name of company: _____

Policy no: _____

Period of insurance: _____

Policy issuing office: _____

DETAILS OF PREVIOUS CLAIMS

19. Have you made any Claims in Past? ☐ YES ☐ NO. If YES, Please give details including

Nature of Accident: _____

Insurance details: _____

Claim amount: _____

DECLARATIONS

I/ We hereby declare that the details given above are true and correct to the best of my belief and knowledge. In event above information or any part thereof is found incorrect, I/We agree that all rights under the policy will be fortified. I/We also agree to provide additional information to the company, if required.

Date: _____ **Insured/ Nominee Signature:** _____

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ATTENDING PHYSICIAN'S STATEMENT

(To be filed by attending Physician only)

1. **Name of insured Person:** _____
2. **Age of insured Person:** _____
3. **Nature of the Accident and Details of Injuries Sustained:** _____

   _____
4. **Does the cause of Accident as stated by the Claimant tally as per your opinion?** ☐ **YES** ☐ **NO**
5. **Are the injuries solely due to the accident?** ☐ **YES** ☐ **NO**

   If No pls. provide the details_____
6. **Was the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition?** ☐ **YES** ☐ **NO**
7. **Was the claimant hospitalized?** ☐ **YES** ☐ **NO**

   If YES, then please provide period of hospitalization: From: _____**To**_____
8. **What treatment/ procedure/ operations performed?**_____

   _____
9. **Give all dates of treatment:**

   Home: From: _____**To**_____

   Clinic/ Hospital: From: _____**To**_____
10. **Was he/she under the influence of intoxicants or drugs at the time of accident?** ☐ **YES** ☐ **NO**
11. **Are you his family doctor?** ☐ **YES** ☐ **NO**

    If you have treated him for any previous illness or injury, please give details

    _____
12. **Have other Doctors been in Attendance or Consultation?** ☐ **YES** ☐ **NO**

    If yes, Please give details: _____

    _____
13. **Has this accident been reported to the Police Authorities?** ☐ **YES** ☐ **NO**

    If yes, Case No: _____ **Police Station.**_____
14. **Is this claimant totally disabled from each and every occupation?** ☐ **YES** ☐ **NO**
15. **How long was or will the claimant be totally disabled from current occupation? From:** _____**To**_____
16. **How long was or will the claimant be partially disabled from current occupation? From:** _____**To**_____
17. **Estimated date of return to Work:** _____
18. **What is the Prognosis?**

_____

_____

Doctor's Signature: _____

Doctors Name: _____

Address and Tel. no. : _____

Date: _____

Regn No: _____

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