Home Guard Plus Policy

Claim Form

TATA AIG INSURANCE
WITH YOU ALWAYS

Tata AIG General Insurance Company Limited: A-501, 5th Floor, Building No.4, Infinity Park, Gen. A.K. Vaidya Marg, Dindoshi, Malad (East), Mumbai 400 097

IMPORTANT:
1. Issuance of the form is not an admission of Liability or a waiver of terms, conditions and exceptions of the insurance contract.
2. Please answer all questions completely. In case of insufficient space, please attach an additional sheet.

Certificate/Policy No. **Period From** **To**

DETAILS OF INSURED

Name (First Name / Middle Name / Surname)

Address

City

State PIN

Phone (O) (R)

Fax Mobile

Date of Birth (D D M M Y Y Y Y) Sex: M F

E-mail id

Please indicate whether claim is in respect of:
- Critical Illness
- Accidental Death
- Permenant Total Disability
- Education benefit
- Involuntary loss of job
- Home standard fire and special perils

CRITICAL ILLNESS BENEFIT

1. **Disease or condition claimed for :**
   - Cancer of specified severity
   - Kidney Failure Requiring Regular Dialysis
   - Multiple Sclerosis with persisting symptoms
   - Major Organ / Bone Marrow Transplant
   - Open Heart Replacement or Repair of Heart Valves
   - Open Chest CABG
   - Stroke resulting in Permanent Symptoms
   - Permanent Paralysis of Limbs
   - First Heart Attack - of specified severity
2. What was the date of first consultation with a Medical Practioner ? (D D M M Y Y Y Y)
3. What was the date of first diagnosis of disease or condition ? (D D M M Y Y Y Y)
4. Name of the hopital and details of confinment for this disease DOA DOD
   Name of the Hospital : _____
   Address : _____
5. Please provide any details of treatment given for any similar or related illness. _____
6. Details of Family Doctor
   Name & Qualification _____
   Address _____
   Tel. No. _____
7. Details of Specialist consulted in the past and reason for consultation : _____
8. Details of Domestic Health Insurance or other Policy covering same loss and Claims history , (if any) : _____

ACCIDENTAL DEATH

Details of accident i.e. how, when, where it took place: _____

_____

Date: D D M M Y Y Y Y Place: _____

FIR No: _____ Location of Police station _____

Name of the Hospital where treatment is being taken: _____

Date of Admission: D D M M Y Y Y Y Date of Discharge: D D M M Y Y Y Y

Provide name, address & Contact No. of your treating physician:

PIN

Phone (O) (R)

Provide name, address & Contact No. of your family physician:

PIN

Phone (O) (R)

Indicate other health insurance coverages, including name, address, policy number & certificate number of insurer:

PERMANENT TOTAL DISABILITY

Details of accident i.e. how, when, where it took place: _____

_____

Date: D D M M Y Y Y Y Place: _____

FIR No: _____

Name of the Hospital where treatment is being taken: _____

Date of Admission: D D M M Y Y Y Y Date of Discharge: D D M M Y Y Y Y

Provide name, address & Contact No. of your treating physician:

PIN

Phone (O) (R)

Provide name, address & Contact No. of your family physician:

PIN

Phone (O) (R)

INVOLUNTARY LOSS OF JOB

1) Details of loan account number.: _____

2) Current employment status : _____ Support with documentary evidence from HR of Co.last attended

3) Medical/Disability certificate from government authority:_____

4) Reason for loss of job : _____

ATTENDING PHYSICIAN'S STATEMENT

1. Patient's Name : _____
2. Age : _____
3. Detailed Diagnosis : _____
4. Type of Symptoms : _____
5. First Date of Symptoms : _____
6. Any other disease / medical condition affecting present condition : _____
7. Hospitalisation Details :
   Name & Address of the Hospital : _____

   Date of Admission : D D M M Y Y Y Y Date of Discharge : D D M M Y Y Y Y
8. Nature of Treatment / Surgical Procedure undergone _____
9. Is illness due to any pre-ex conditions : ☐ Yes ☐ No
10. Nature of disability : _____ Percentage of disability : _____
11. Time required for Recovery: _____

Attenting Doctor's Name : _____

Date: D D M M Y Y Y Y

Signature: _____

EDUCATION BENEFIT

Name of child/Children : _____

Age: ☐☐☐ yrs

Name of the Education institute : _____

STD. _____

Name of the Legal Guardian (if child is minor) _____

HOME STANDARD FIRE AND SPECIAL PERILS (MATERIAL DAMAGE)

Details of property loss : _____

Amount of Loss : _____

FIR No. & Details : _____

Date of loss / location : _____

AUTHORISATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize any hospital, physician, or other person who has attended or examined me, to furnish to the company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records, a photostat copy of this authorization shall be considered as effective and valid as the original.

_____

Signature of insured :

Date: D D M M Y Y Y Y

Place: _____

AUTHORIZATION

I hereby declare that I have suffered injuries / loss as described above and all the details given are ABSOLUTELY TRUE AND CORRECT.

I hereby agree to forfeit all my rights to compensation if any of the foregoing facts and / or details are found to be false or incorrect.

Date: D D M M Y Y Y Y

Place: _____

_____

Signature of insured/Nominee:

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Insurance is the subject matter of the solicitation.
Purchase of Tata AIG General Insurance Company Limited products are purely on voluntary basis.
For more details on risk factors, terms and conditions please read sales brochure carefully before concluding a sale.

Tata AIG General Insurance Company Limited

Registered Office: Peninsula Business Park, Tower A, 15th Floor, G.K. Marg, Lower Parel, Mumbai – 400013

24X7 Toll Free No: 1800 266 7780 or 1800 22 9966 (For senior citizens)
Fax: 022 6693 8170 Email:customersupport@tataaig.com www.tataaig.com

IRDA of India Registration No: 108 CIN:U85110MH2000PLC128425

Home Guard Plus Policy UIN: IRDAI/NL-HLT/TAGI/P-H/V.II/287/14-15