Accident Guard Plus

Claim Form

TATA AIG INSURANCE
WITH YOU ALWAYS

IMPORTANT: 1 Issuance of this form is not an admission of Liability or a waiver of the terms, conditions and exceptions of the insurance contract.
2. No claim will be admitted without a Medical Report as per format to be obtained at claimant's expense.

Claim No. Policy No.

1. Personal Details

NAME: a) Insured
b) Claimant
Address
District City
Pincode* State Mobile No.
Occupation Age yrs e-Mail

2. Details of Accident

Time and Date : D D M M Y Y Y Y
Place and Location (full address)
District City
Pincode * State Mobile No.
Cause Description

3. Details of Injuries

Specify Injured Parts of Body
Total Disablement (if any)
Percentage % In Words:

4. Witnesses

1) NAME:
Address
District
City
Pincode* State
Phone No.

2) NAME:
Address
District
City
Pincode* State
Phone No.

5. Treatment Details

A) Csualty Doctor
Address
District
City
Pincode* State
Phone No.
Registration No.

B) Family Doctor
Address
District
City
Pincode* State
Phone No.
Registration No.

C) Hospital(s)
NAME:
Address
District City
Pincode* State
Phone No.

6. Contact Details

Address where available
District City
Pincode* State
Phone No.

(Please available at this place where our representative may call on you)

7. Confinement

A) Total Confinement From D D M M Y Y Y Y To D D M M Y Y Y Y
(This should be the actual days when fully confined to bed on Medical Advice)

B) Partial Confinement From D D M M Y Y Y Y To D D M M Y Y Y Y
(This should be the days when partially confined to bed)

Accident Guard Plus UIN: TATPAIP23086V032223

8. Amount of Claim

A) Death Amount (Rs)
B) Permanent Total Disablement Amount (Rs)
C) Permanent Partial Disablement Amount (Rs)
D) Education Benefit Amount (Rs)

9. Past History

A) Have you made any claims in the PAST? YES NO
B) If YES, please give details including accident and Insurance details _____

10. Are you insured under any other policy? YES NO

If YES, please give full details _____

11. Have the Police Authorities been informed of this accident? YES NO

If YES, Case No. _____ Police Station _____

I / insured hereby declare that I have / has suffered injuries 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. I further authorize the hospital, doctor, diagnostic laboratory, organization, establishment or any other body or person dealt with in the course of this claim to give any informationn or document sought for by the Insurance Company.

Date: D D M M Y Y Y Y

Place:

Signature of the Insured / Signature of the Claimant (if other than insured)

Attending Physician's Statement

Please answer all the questions

1) Name of Injured Person:
2) Address
District City
Pincode* State Age yrs
3) Nature of the Accident and Details of Injuries Sustained _____
4) Does the Cause of Accident as stated by the Claimant tally with the Injuries noticed by you? _____
5) Are the injuries solely due to the accident or traceable to any previous injuries / disease / infirmities? _____
6) Was the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition _____
7) Was the Claimant hospitalized? If so for what period? _____
8) What treatment was given and Operations performed? _____
9) Give all dates of treatment:
Clinic / Hospital: From D D M M Y Y Y Y To D D M M Y Y Y Y
Home: From D D M M Y Y Y Y To D D M M Y Y Y Y
10) Was he / she under the influence of intoxicants or drugs at the time of accident? _____
11) Are you his usual medical attendant? 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?
If yes, please give details. _____
13) Has this accident been reported to the Police Authorities? If yes, Case No. _____ Police Station _____
14) Is this claimant totally disabled from each and every occupation? _____
15) (a) How long was or will the claimant be totally disabled from current occupation? From D D M M Y Y Y Y To D D M M Y Y Y Y
(b) How long was or will the claimant be partially disabled from current occupation? From D D M M Y Y Y Y To D D M M Y Y Y Y
(c) Estimated date of return to work. _____
16) What is the Prognosis? _____

Doctor's Signature _____ Date: D D M M Y Y Y Y Registration No.: _____

Doctors Name:
Address
District City
Pincode* State
Phone No.

Disclaimer: Insurance is the subject matter of solicitation. For more details on benefits, exclusions, limitations, terms and conditions, please refer sales brochure / policy wordings carefully, before concluding a sale.

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