Toll Free Phone: 1800-103-8889
Toll Free Fax: 1800-103-9998
E-mail ID: GCI.Health@generalicentral.com

ACCIDENT SURAKSHA CLAIM FORM

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:

State																		Pin code									
Mobile											Landline																
Email																											
Occupation																											

DETAILS OF ACCIDENT

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

4. Please state the place of Accident : _____

5. Please provide brief details of accident/ incidence in a separate sheet and enclose with claim form (Mandatory)

TYPE OF CLAIM (Please tick the section/s under which the claim is lodged)

6. Primary Cover

Accidental Death ☐ Permanent Total Disablement ☐ Permanent Partial Disablement ☐ Temporary Total Disablement ☐

7. Additional Cover

*Accidental Medical Expenses ☐ Accidental Hospitalization ☐

**Please provide details of Medical Expenses incurred in a separate sheet showing Bill Numbers, Expense Head, Dates and Amount.*

8. In Case of Death: Please provide following details:

a. Name of Nominee: _____

b. Nominee's Mobile No. : _____ E Mail ID: _____

**In case nominee has been declared at the time of proposal, then no change will be accepted at the time of claim. Legal Heir Certificate is mandatory if nominee details are not available in policy.*

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9. In case of Confinement/ Away from work: Please mention the period of confinement
(This should be the actual days when away from work on Medical Advice)

Total Confinement Period: From _____(DD/MM/YYYY) To_____(DD/MM/YYYY)

10. Have the Police been informed about the accident? □ YES □ NO

If yes, please give following details and submit the FIR and Medico Legal Certificate (MLC) along with claim documents.

MLC No: _____FIR No: _____

Name & Address of the Police Station: _____

11. Please provide following details of CASUALTY DOCTOR (*Doctor who has first treated the patient after the accident*)

Doctor Name: _____

Hospital / Clinic Name: _____

Hospital / Clinic Address: _____

Contact No: _____

DETAIL OF OTHER HEALTH / PERSONAL ACCIDENT POLICIES AND CLAIMS

12. Are you insured under any other Policy? □ YES □ NO

(If yes, Please provide following details)

Name of the Insurance Company: _____

Policy No: _____

Period of Insurance: _____

Policy Issuing Office: _____

Have you made any Claims in Past? □ YES □ NO

(If yes, please provide details including)

Nature of Accident: _____

Claim Amount: _____

DECLARATIONS

I/ We _____hereby declare that the details given above are true and correct to the best of my/our 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 forfeited. I/We also agree to provide additional information to the company, if required.

Date: _____

Place: _____

_____
Signature of Insured/ Nominee

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ATTENDING PHYSICIAN'S STATEMENT

(To be filled completely and signed by Attending Physician only. Incomplete Statement will lead to closure of claim)

1. Name of Injured Person: _____ 2. Age of Injured Person: _____
3. Date of Accident: _____ (DD / MM / YY) Time of Accident: _____ (AM / PM)
4. History and Alleged Cause of Injury:

_____

_____

_____

_____

_____

5. Nature of the Accident, Clinical Details of Injuries Sustained:

_____

_____

_____

_____

_____

6. Provisional Diagnosis: _____
7. Does the Cause of Accident as stated by the Claimant tally as per your opinion? □ YES □ NO
8. Are the injuries solely due to the accident? □ YES □ NO

   If yes, please provide the injury certificate: _____
9. Please specify exact anatomical site and extent of injury: _____
10. Do the injuries appear fresh or old: □ FRESH □ OLD
11. Please confirm probable duration since when the injury was sustained: _____
12. 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
13. Was the claimant hospitalized? □ YES □ NO

    If yes, then please provide period of hospitalization: From: _____ To _____
14. What treatment/ procedure/ operations were performed? _____

_____

15. Was he/she under the influence of intoxicants or drugs at the time of accident? □ YES □ NO
16. Are you his Family Doctor? □ YES □ NO

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

_____

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17. Has this accident been reported to the Police Authorities? □ YES □ NO

MLC No: _____ FIR No: _____

Name & Address of the Police Station: _____

12. Please specify nature of Disability: _____

13. In case of Permanent Partial Disablement: Please mention Disability Percentage

Percentage: _____ (%) _____ (In words)

14. How long was or will the claimant be totally disabled? From: _____ To _____

Doctor's Name: _____ Signature: _____

Address and Contact No: _____

Date: _____ Registration Number: _____

AUTHORIZATION FOR TRANSFER OF CLAIM AMOUNT BY NATIONAL ELECTRONIC FUND TRANSFER (NEFT)

Please attach any of the following documents carrying the required information (In case of Group Personal Accident policy, NEFT is to be provided only if the beneficiary is employee or individual)

Document List (Any One of the Following)	Required Information on the Document Submitted
1. Photocopy of cheque with printed name of Proposer / Employee / Nominee (in case of death) 2. Bank Passbook 3. Bank Statement 4. Duly filled NEFT form authorized by the bank	1. Name of Proposer / Employee / Nominee (in case of death) 2. Bank Account Number 3. Bank Account Type 4. IFSC Code 5. Bank Name & Branch name

I hereby declare that in case of a Group Personal Accident Policy, the claim amount shall be paid as per the beneficiary defined in the Group Policy. I hereby declare that the particulars given by me are correct and complete and request you to remit any amount due to me, if any to the provided bank account as per document submitted by me. I herewith further declare that if any transaction is delayed or not effected at all or is wrongly credited to any other account for reasons of incomplete or incorrect information as provided by me, I shall not hold Generali Central Insurance Company Limited ("Company") or any of its directors, employees or agents responsible for the same. I also declare that the remittance of any dues to the provided bank account shall be considered as full and valid discharge of its obligations by the company. I also undertake to advise any change in the particulars of my bank account to facilitate updation of records for the purpose of credit of any amount due, through NEFT.

Name of Employee / Proposer: _____

Signature of Employee / Proposer: _____

Claimant Name: _____

Date: _____ Place: _____

FEEDBACK AND SUGGESTIONS

We thank you for choosing Generali Central Insurance Company Limited as your Insurance provider. We always strive to ensure that our service levels exceed our customer's expectations. In the spirit of this endeavor, we will greatly appreciate your valuable inputs and feedback. Kindly provide your feedback on your experience with Generali Central Insurance Company Limited and any suggestions for improving our services. We value your time and promise to evaluate your suggestions for improvement of our service.