CLAIM FORM FOR PERSONAL ACCIDENT INSURANCE

* The issue of this form is not to be taken as an admission of liability.

Claim Intimation Number:			
Policy/Certificate No.			
Policy Period	**From**		**To**

SECTION A – DETAILS OF INSURED			
a) Name of the Insured			
b) Address			
c) Date of Birth	DD/ MM / YYYY	d) Gender	☐ Male ☐ Female ☐ Third Gender
e) Contact No.			
f) Email ID			
Details of Claimant (if different than insured)			
g) Name of the Claimant			
h) Address			
i) Contact No.			
j) Email ID			
k) Relationship with Insured			

SECTION B – DETAILS OF ACCIDENT	
a) Date of Accident	
b) Time of Accident	
c) Cause of Accident	
d) Details of Accident	
e) Place/Address of Accident	
f) In case of death, please mention date of death	

SECTION C – DETAILS OF WITNESS	
a) Were there any witness to the accident? (If 'Yes', provide details)	
b) Name of witness	
c) Address of witness	
d) Contact details of witness	
e) Is witness relative of Claimant?	

SECTION D - POLICE REPORT DETAILS	
a) Has the loss been reported to the police authority?	
b) If 'No', reason for not reporting	
c) First Information Report (FIR) No.	
d) Medico Legal Case (MLC) No.	
e) Report Date	
f) Address of Police Station	
g) Contact No.	
h) Date of Admission	
i) Date of Discharge	

SECTION E – DETAILS OF OTHER INSURANCE				
a) Is the accident covered under any other insurance?				
b) If yes, Name of insurance company				
c) Policy No.				
d) Sum Insured (Rs.)				
e) Policy Period	From		To	

SECTION F – PAYEE DETAILS [Payable to Nominee in Case of Death (*All fields are mandatory)]	
a) Payee Name	
b) Bank Account No.	
c) Bank Name	
d) Branch Name	
e) IFSC code	
f) MICR No.	
g) PAN No.	

***Note:** It is agreed that the policyholder/claimant will intimate in writing to Galaxy Health Insurance Company Limited about any changes in bank account details. Please attach a cancelled cheque pertaining to the same account.

SECTION G – Select the benefits for which a claim is being made (tick against the benefit(s))

☐ Accidental Death Benefit ☐ Permanent Total Disability Benefit

SECTION H – ANY OTHER INFORMATION YOU WISH TO PROVIDE

I/we, the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect, and I/We agree that if I/We have made, or make in any further declaration, the Company may require in respect of the said accident, any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited.

Name of Insured/Claimant: _____ Date : _____

Signature of Insured/Claimant: _____ Place : _____

ANNEXURE 1: TO BE COMPLETED BY NOMINEE IN THE EVENT OF INSURED'S DEATH			
a) Name of Nominee			
b) Relationship with Insured			
c) Date of Birth		d) Gender	☐ Male ☐ Female ☐ Third Gender
e) Address			
f) Contact No.			
g) E-mail ID			

I/we hereby declare and warrant the truth of the foregoing particulars in every respect. I/We agree that if I/We have made or shall make a false or untrue statement, suppression, or concealment, my/our right to compensation shall be forfeited.

I/we also hereby declare that I am/we are accepting the amount in full discharge of your obligations under the policy to the insured person and/or his/her legal heirs. I/we will hold you indemnified in the event of any claim under this policy being made against you by any other person or persons.

Name of Nominee: _____ Date : _____

Signature of Nominee: _____ Place : _____

ANNEXURE 2: MEDICAL CERTIFICATE (to be filled by treating doctor)				
1. Name and address of insured				
2. Gender	☐ Male ☐ Female ☐ Third Gender		3. Date of Birth/Age	
4. Nature of the Accident and details of injuries sustained				
5. Cause of accident				
6. i) Are the injuries solely due to accident?				
ii) Traceable to any disease? If yes, give details				
iii) Traceable to any previous injury? If yes, give details				
7. Was insured under influence of drugs/alcohol or intoxicants at the time of accident?				
8. Is the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his/her condition or delay improvement? If yes, give details				
9. Nature of Disablement	Permanent Total Disablement			☐ YES ☐ NO
10. Details of Disablement				
11. Details of treatment given				
12. According to you, how long should the injured person be confined to bed/house as the direct and sole consequence of the injury sustained?	From		To	
13. During this period, will the injured person be able to attend to his/her normal duties? If yes, from date				
14. If 'No', please state probable date of his / her being able to attend to his normal duties				

I certify that I have examined the above named Insured, the above statements are correct	
i) Name of treating Doctor	
ii) Qualification	
iii) Registration No.	
iv) Address	
v) Contact No.	
vi) E-mail ID	

Date: _____ Place: _____

Signature of the doctor with stamp: _____ Stamp of hospital:

SECTION I - ENCLOSURES CHECKLIST	
1. Accidental Death	
☐ Claim form duly filled & signed	☐ Claim Intimation
☐ Police Investigation Report	☐ Copy of FIR (First Information Report) / Spot Panchnama / Inquest Panchnama
☐ Death Certificate	☐ Death Summary
☐ Post Mortem Report	☐ Original Legal Heir Certificate (in case nomination has not been filled by deceased)
2. Permanent Total Disablement	
☐ Claim form duly filled & signed	☐ Claim Intimation
☐ Police Investigation Report	☐ Copy of FIR (First Information Report) / Spot Panchnama / Inquest Panchnama
☐ Photograph of the injured with reflecting disablement	☐ Disability Certificate from appropriate government authority
☐ Medical Certificate from treating doctor	☐ Leave Certificate from the employer
☐ Investigation Reports	☐ Treatment Papers