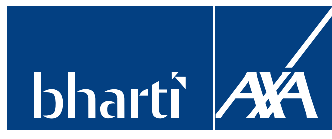
REGD. OFFICE:
BHARTI AXA GENERAL INSURANCE COMPANY LIMITED,
RMZ Infinity, B - Tower, 2nd Floor, No. 3, Old Madras Road,
Bangalore - 560016. Tel: 080-40260100.
Toll-Free Helpline: 1800-103-2292
E-mail: claims@bharti-axagi.co.in
SMS <CLAIM> to 5667700
Website: www.bharti-axagi.co.in



PERSONAL ACCIDENT INSURANCE CLAIM FORM

ISSUANCE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY.

Please fill this form in **Block Letters** and **Tick the Boxes** ☑ where appropriate and do not leave any column unanswered.

PART - I

Policy Number: |_|_|_|_|_|_|_|_|_|_| Claim Number: |_|_|_|_|_|_|_|_|_|_|

Period of Insurance: D D M M Y Y Y Y to D D M M Y Y Y Y

INSURED DETAILS:

Name of the Insured ____________________

Address ____________________

____

____

____________________ City ____________________

Pin code ____________ State ____________________

Contact Nos. Mobile No. ____________ Office +91 ____________

Residence +91 ____________ E-mail ID ____________

For Group Policies:
Corporate Name ____________________ Employee Code ____________

INJURED/DECEASED DETAILS:

Name of the Insured/Deceased ____________________

Gender: ☐ Male ☐ Female

Relationship with the Insured ____________________ Date of Birth D D M M Y Y Y Y

CLAIM DETAILS:

Date of Accident D D M M Y Y Y Y Time of Accident H H M M

Place of Accident ____________________ (Kindly provide exact location of accident)

Witnesses, if any ____________________

Brief narration of accident:

____

____

____

Whether FIR filed? ☐ Yes ☐ No If yes, FIR No. ____________

Police Station ____________________

If no, please state reasons for not informing police:

____

____

Name of attending Doctor/Physician ____________________

(Please attach a report from the attending physician in attached format)

Name of Hospital, where admitted/treated ____________________

Address of Hospital ____________________

____

____

Kindly provide us with the present contact details where our representatives/Doctor could examine the injured. (applicable only in injury cases)

Date of admission D D M M Y Y Y Y   Date of discharge: D D M M Y Y Y Y

Nature of Claim: ☐ Non-fatal Injury ☐ Fatal Injury

Non-fatal Injury:

a) Nature of Injury

b) Nature of disablement

c) Extent of disablement (Percentage of disability as assessed by the attending doctor)

d) Period of temporary total disablement

e) Total period of confinement: From D D M M Y Y Y Y To D D M M Y Y Y Y (From the date of accident till recovery)

Fatal Injury: Cause of death as per attending doctor

Post Mortem: Date conducted D D M M Y Y Y Y

Hospital where conducted

Amount of claim (Please mention & include under what head claims are lodged viz. Medical expenses, funeral expenses, educational grant etc. & attach separate sheet if the space is insufficient)

Sl. No.	Details	Bill No.	Date	Amount (Rs.)
			Total	

Are you currently insured under any other accident insurance policies? ☐ Yes ☐ No
If yes, kindly complete the following table.

Sl. No.	Name & address of Insurance Company	Policy No.	From	To	Sum Insured (Rs.)

Please furnish the following list of documents:

- ☐ Discharge Summary in full
- ☐ FIR
- ☐ Post mortem report
- ☐ All prescriptions along with medical reports
- ☐ All hospital/drug bills & receipts in original
- ☐ Attached physician's statement duly completed by him/her
- ☐ Personal identification photo ID card (PAN, DL, Ration Card etc.), copy of bank passbook of assignee (in death claims)

INSURED'S / PATIENT'S CONSENT FOR ACCESS TO MEDICAL RECORDS & DECLARATION

I/We hereby authorize Bharti AXA General Insurance Co. Ltd. or any other individual/agency engaged by Bharti AXA to obtain all medical records pertaining to the above patient available with any hospital/doctor. The Insurance Company or their representatives or any other authorised agency engaged by them may be allowed access & possession of medical records pertaining to the above patient. The necessary charges will be borne by the Insurance Co. or their authorised agencies.

I/We agree to provide additional information to the Company, if required. I/We the abovenamed, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and if I/We have made, or in any further declaration the Company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, the policy shall be void and all rights to recover thereunder in respect of past or future claims shall be forfeited.

Date: ____________ Place: ____________

Signature of Insured/Assignee

PART-II
ATTENDING PHYSICIAN'S STATEMENT

Name of the Injured/Deceased ______________________

Age [|] Years   Gender: ☐ Male ☐ Female

Address ______________________

____

City ____________ Pin code ____________ State ____________

Date when injured was brought to you first: D D M M Y Y Y Y

Diagnosis: ______________________

____

Please provide previous medical history of the injured:

____

____

Is the present condition/disability attributable to conginetal defect? If yes, please provide details:

____

____

Nature of the accident and details of injuries sustained:

____

____

Are the injuries solely due to the accident or traceable to any previous injuries/disease/infirmities?

____

____

Nature of treatment/surgery performed for present illness/disease/injury:

____

____

____

Was injured/deceased under the influence of intoxicants or drugs at the time of accident?
If yes, please provide details of diagnosis done and alcohol content.

____

____

Are you his/her usual medical attendant? If yes, please give detailsof previous treatment for any illness/disease/injury:

____

____

Attending Doctor's Name ______________________

Registration No.______________________

Address ______________________

City ____________ Pin code ____________ State ____________

Telephone No. ______________________

Date: ____________

____
Doctor's Signature

Insurance is the subject matter of the solicitation.

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