TATA AIG INSURANCE
WITH YOU ALWAYS

TATA-AIG GENERAL INSURANCE COMPANY LTD
A-501, 5TH FLOOR, BUILDING NO.4,
INFINITY PARK, GEN. A.K. VAIDYA MARG,
DINDOSHI, MALAD (EAST), MUMBAI 400 097

HOSPITAL CASH / MEDICAL EXPENSES CLAIM FORM

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 If the space provided is insufficient, please attach additional sheets

Policy No. _____ **Claim No. _____**

1. DETAILS OF INSURED

NAME _____

Address _____

City _____State_____ PIN _____

Name of the contact person _____Designation _____

Tel_____Fax_____ Email ID_____

3. DETAILS OF ACCIDENT

Time and Date _____

Place and Location _____

Address _____

City _____State_____ PIN _____

4. DETAILS OF INJURY

Please describe details of injury sustained _____

Specify the injured parts of body _____

5 TREATMENT DETAILS

Name of the Attending Doctor _____

Tel_____Fax_____ Email ID_____

Date (s) of consultation _____ _____ _____ _____ _____ _____

Name of the Hospital(s) (If hospitalized) _____

Address _____

City _____State_____

PIN _____

Tel_____Fax_____ Email ID_____

Period of hospitalization : From _____ to _____

Diagnosis / Surgery _____

6 AMOUNT OF EXPENSES

a) Medical Expenses

Sl No	Date	Details	Amount	Sl No	Date	Details	Amount

Please attach a separate sheet if the space is insufficient.

b) In hospital cash (If covered).

From	To	Amount

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

I hereby declare that I have 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 authorise the hospital, doctor diagnostic laboratory, organisation, establishment or any other body or person dealt with in the course of this claim to give any information or document sought for by the Insurance Company.

Date:
Place: **Signature of the Insured**

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ATTENDING PHYSICIAN'S STATEMENT

PLEASE ANSWER ALL QUESTIONS

1 Name Age of Injured Person: _____

2 Address _____

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 : Home: From---------- ----To----------
Clinic/Hospital :From----------To----------

10 Was he under the influence of intoxicants or drugs at the time of accident ?_____

11 Are you his usual medical Attendant ?
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----- ---------- To----------
(b) Estimated date of return to Work. _____

16 What is the Prognosis?

Doctor's Signature & Stamp **Date:** **Regn No:**

Doctors Name:
Address and Phone No.