

Bharti AXA General Insurance Company Limited

☎1800-103-2292
□ claims@bharti-axagi.co.in
§ SMS <CLAIM> to 5667700

SMS <CLAIM> to 566770

SmartPersonal Accident - Individual Insurance Claim Form

Important Note

Issuance of this form not to be taken as an admission of liability

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

Part - I												
Policy Number:	Claim Number:											
Period of Insurance: DIDIMIMIYIYIYI to DIDIMIMIYIYIYI INS ID No.:												
1 Insured details												
Name of the Insured:												
Address Pin cod Contact Nos. Mobile No. Residence +91	e City City B State Cfice +91 E-mail ID											
For Group Policies: Corporate Name	Employee Code											
2 Injured/deceased details:												
Name of the Insured/Deceased Relationship with the Insured	Gender: Male Female Date of Birth D D M M Y Y Y Y											
3 Claim details:												
Date of Accident DIDIMMY Place of Accident Witnesses, if any Brief narration of												
Whether FIR filed? Yes Police Station If no, please state reasons for not	No If yes, FIR No.											
.,,,												
Name of attending Doctor/Physicia	n (Please attach a report from the attending physician in attached format)											
Name of Hospital, where admitted/treated												
Address of Hospital												

1st Floor, The Ferns Icon, Survey No. 28, Next to Akme Ballet, Doddanekundi, Off Outer Ring Road, Bangalore – 560037. ST Registration No.: AADCB2008DST001 Co. Registration No.: U66030KA2007PLC043362 Kindly provide us with the present contact details where our representatives/Doctor could examine the injured. (applicable only in injury cases)

Date of au	$Imission D \mid D \mid M \mid M \mid Y \mid Y \mid Y \mid Y \mid Y $	ate of discharge:		Y Y Y	
Nature of (Claim: Non-fatal Injury Fatal	Injury			
	a) Nature of Injury				
Injury:	b) Nature of disablement				
(c) Extent of disablement		(Percentage of disal	ulity as assessed l	by the attending doctor)
	d) Period of temporary total disablement		(reicentage of disa		by the attending doctor)
	e) Total period of confinement: From		Y To DDN	1 M Y Y Y	(From the date of accident till recover
Fatal Injury	y: Cause of death as per attending doc	tor			
	Post Mortem: Date conducted		Y		
	Hospital where conducted				
	f claim (Please mention & include under v al grant etc. & attach separate sheet if th			edical expenses	s, funeral expenses
SI. No.	Details		Bill No.	Date	Amount (Rs.)
			Tota	1	
-	rrently insured under any other accident i dly complete the following table.	insurance policies	?	Yes No	•
SI. No.	Name & address of Insurance Company	Policy No.	From	То	Sum Insured (Rs.)
Diagon fur	nish the following list of documents:				
	scharge Summary in full	FIR	Post m	ortem report	
	prescriptions along with medical reports		/drug bills & rece	•	
	tached physician's statement duly			. 0	Detion Cord ata
					DL, Ration Card etc
Att	mpleted by him/her	copy of ban	ik passbook of as	ssignee (in deat	h claims)

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:

Downloaded from www.insureatclick.com - Broker : Loyal Insurance Brokers Ltd.

Place:

Signature of Insured/Assignee





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If any detail or information is not readily available, please do not delay despatch of this report and such particulars may be sent later.

Part - II: Attending physician's sta	atement														
Name of the Injured/Deceased															
	Age Years Gender: Male Female														
Address															
	City														
Pin code	State														
Date when injured was brought to you Diagnosis:	first: D D M M Y Y Y Y														
Please provide previous medical histor	ry of the injured:														
Is the present condition/disability attri	ibutable to conginetal defect? If yes, please provide details:														
Nature of the accident and details of in	njuries sustained:														
Are the injuries solely due to the accid	lent or traceable to any previous injuries/disease/infirmities?														
Nature of treatment/surgery performed	d for present illness/disease/injury:														
Was injured/deceased under the influent for the influence of the second	ence of intoxicants or drugs at the time of accident? osis done and alcohol content.														
Are you his/her usual medical attenda	nt? If yes, please give detailsof previous treatment for any illness/disease/injury:														



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Attending Doctor's Name																	
Registration No.																	
Address																	
					С	ity											
Pin code					S	tat	е										
Telephone No.																	

Date:

Doctor's Signature

Insurance is the subject matter of the solicitation.

