L&T Insurance

my:health
Personal Accident Insurance

Claim Form

Toll Free Number **1800-209-5846 (1800-209-LTIN)** | Website **www.ltinsurance.com** | SMS **'LTI' to 5607058 (56070LT)**

GUIDELINES TO FILL THE FORM

1. Please fill the form in BLOCK LETTERS. Please answer all questions fully and correctly. All details with * are mandatory.
2. Please leave one box blank between two words while writing the ADDRESS.
3. Kindly contact the Company's Office or Agent for any doubts or clarifications on the claim form.
   PLEASE USE ONLY ORIGINAL CLAIM FORM. PHOTO COPIES WILL NOT BE ACCEPTED BY THE COMPANY.

Policy No: Claim No:

Registration Date: D D M M Y Y Y Y Employee/Member ID no.:

1. POLICY HOLDER INFORMATION (Please enter details of the Insured)

Title* (Pls. Tick): ☐ Mr. ☐ Ms. ☐ Mrs.

Name*: F I R S T M I D D L E L A S T

Correspondence Address:

Block/Flat No.*: Floor No.: Building Name*:

Street Name*: Locality:

Landmark*:

City/Village*: Pincode*:

Post Office: Fax No.:

Mobile No.*: Landline*: S T D

Email ID 1:

Email ID 2:

Profession or Occupation:

If the correspondence address mentioned above is different from the correspondence address in the policy, do you wish to modify the correspondence address on the policy? ☐ Yes ☐ No

2. POLICY DETAILS

Sum Insured: Table of Cover:

3. DETAILS OF ACCIDENT

a. Name of the claimant:
F I R S T M I D D L E L A S T

b. Relationship with the employee/ member: ☐ Self ☐ Spouse ☐ Children ☐ Parent ☐ Sibling

c. Date of accident: D D M M Y Y Y Y d. Time of accident: h h : m m

e. Place of accident:

f. Particulars of the accident: .....

.....

g. Nature of injury received (if to limb or eye state whether right or left): .....

h. Nature of disablement:

i. Extent of disablement:

j. Period of temporary total disablement: D D M M Y Y Y Y To D D M M Y Y Y Y

k. Present state of incapacity: ....

l. Name and address of surgeon in attendance: ....

....

m. Name and address of the witness: ....

....

n. Where and when can a Medical Officer of this Company visit you, if necessary: ....

....

o. Expenses for additional in built Covers (to be considered subject to coverage & limits under the policy)

- Transportation of Dead Body / Funeral Expenses: ₹
- Ambulance Costs: ₹
- Out-Patient Costs: ₹

p. I. Details of Medical Expenses (incase of medical expenses extension): ₹

II. Expenses Incurred on travel of Insured / Relative (wherever extension opted): ₹

III. Expenses Incurred on Support Items of Insured / Relative (wherever extension opted): ₹

q. Are you insured in any other office or offices of the Company or any other company, granting compensation for accident? ☐ Yes ☐ No

If so state name and address of company or companies and amount of insurance: ....

....

DECLARATION

I/We hereby declare that the foregoing statements made by me/us are true in all respects, that I/We have not attempted to conceal from the Company anything with which it ought to be made acquainted and that if I/We have made or in any further declaration the Company may require shall make any false or fraudulent statement or untrue averment whatever, the Policy shall be void and my/our right to compensation forfeited. I am/We are willing if required, to make and provide to the Company a statutory Declaration of the whole of the foregoing statement or of any other statement made in connection with this claim.

Witness

Name: ....

Signature: ....

Place: ....

Date: ....

Signature of Insured

DOCUMENTS TO BE SUBMITTED ALONG WITH THE DULY FILLED & SIGNED CLAIM FORM

Accidental Death Claims:

- Death Certificate
- Copy of Post Mortem report (where it is conducted)
- Newspaper cutting (incase the accident has been reported by press)
- FIR / Police Panchnama / Final Investigation Report (incase of accident outside residence)
- Copy of treatment papers, if any

Permanent Disablement Claims:

- Copy of treatment papers, if any
- Disability Certificate or Medical Report determining disability
- FIR / Police Panchnama (incase of accident outside residence)

Temporary Total Disability Claims:

- Copy of treatment papers and copy of medical investigation report / X-rays
- Fitness Certificate from the treating doctor
- Leave Certificate (for salaried people)
- Salary Certificate / income proof / ITR

Transportation of Mortal Remains & Funeral Charges:

- Bills and receipt towards cost if transportation of the mortal remains to the place of residence / hospital and/or cremation / burial ground
- Receipt of cremation charges

Ambulance:

- Bills / Receipts from a registered Ambulance Service Provider

Out-Patient Costs:

- Consultation Papers
- Bills and receipts towards medical expenses
- Copy of the medical test reports

Education Grant:

- Proof of number of dependent children viz. Ration Card
- Age proof of the dependent children

Loss of Employment:

- Salary Certificate from the employer
- The letter from the employer terminating, dismissing the Insured from the present job mentioning the reason and effective date of termination, dismissal

Hospitalization due to Accident:

- Copy of document of hospitalization
- Certificate from treating doctor about the diagnosis and line of treatment given during hospitalization
- Bills and receipts towards medical expenses
- Copy of the test reports

Cost of Travel:

- Copy of travel tickets or relevant proof of travel to / from the destination where accident has taken place

Cost of Support Items:

- Medical Practitioners presciption
- Original Bills in respect of the item

MEDICAL CERTIFICATE

BY ATTENDING DOCTOR

(Claim must be supported by medical evidence furnished by the Insured at his/her expense)

1. a) Name of Claimant/Injured Person: F I R S T M I D D L E L A S T

   b) Age: years

2. Date on which you first attended claimant for this injury: D D M M Y Y Y Y

3. a) Nature and cause of accident .....

   b) Please specify the parts of the body, if to eye or limb, state left or right .....

   c) Whether the appearance of the injuries are consistent with the account given for the accident .....

4. Is claimant suffering from any disease or illness or circumstance which may have contributed to the accident or likely to aggravate his/her condition or which may tend to retard recovery? If so, give particulars. .....

   .....

5. Are the injuries solely due to the accident or traceable to any previous injuries? .....

   .....

6. Was the Injured Person under the influence of intoxicants or drugs at the time of accident? ☐ Yes ☐ No If Yes, give details .....

   .....

7. Has claimant been totally prevented from attending to any portion of his business? ☐ Yes ☐ No If Yes, for how long? .....

   .....

8. a) Was the Injured Person Hospitalised? ☐ Yes ☐ No

   b) If Yes, Period from D D M M Y Y Y Y to D D M M Y Y Y Y

   c) Name of Hospital: .....

   d) Details of treatment given/operations performed? .....

   .....

9. Please provide the present condition of the Injured Person? .....

10. Please indicate the nature and duration of Disability:

Nature of Disability	Description	Duration
Permanent Total Disablement		
Permanent Partial Disablement		
Temporary Total Disablement		

Having personally examined the above named Claimant, I certify that the above statements are correct and that the injured person/Claimant is necessarily disabled by the accident referred to.

Signature: ..... Date: .....

Name: F I R S T M I D D L E L A S T

Qualification:

Registration Number:

Address: