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REGD. OFFICE:
BHARTI AXA GENERAL INSURANCE COMPANY LIMITED,
RMZ Infinity, B - Tower, 2nd Floor, No. 3, Old Madras Road,
Bangalore - 560016. Tel: 080-40260200.
Toll-Free Helpline: 1800-103-2292
E-mail: claims@bharti-axagi.co.in
www.bharti-axagi.co.in

bharti AXA GENERAL INSURANCE

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 _____

_____

_____

BAGI/CF/GPA/M-E/07-08

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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, provide details)

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

Do you wish to provide any other information as relevant to the claim made? ☐ Yes ☐ No

If yes, details (If required you may please attach a separate sheet):

Please furnish following documents (as applicable with nature of loss):

- ☐ Discharge Summary in full
- ☐ All prescriptions along with medical reports
- ☐ Attached physician's statement duly completed by him/her
- ☐ FIR
- ☐ Post mortem report
- ☐ All hospital/drug bills & receipts in original
- ☐ 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

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