Hospital Cash/Medical Expenses

Diagnosis / Surgery

Claim Form



Tata AIG General Insurance Company Limited: A-501, 5th Floor, Building No.4, Infinity Park, Gen. A.K. Vaidya Marg, Dindoshi, Malad (East), Mumbai 400 097

n No.						Policy	No.				
ERSONAL DETA	ILS					,,					
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	State					PIN					
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ETAILS OF INJU	RY										
Please describ	e details of injury s	ustained _									
Specify the inj	ured parts of body_										
REATMENT DET	AILS										
Name of the Att	ending Doctor					(P)					
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5. AMOUNT OF EXPENSES

a) Medical Expenses

SI No	Date	Details	Amount
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Please attach a separate sheet if the space is insufficient.

b) In hospital cash (If covered)

From	То	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

ATTENDING PHYSICIAN'S STATEMENT

PLEASE ANSWER ALL QUESTIONS

1	Name of Injured Person:
2	Age of Injured Person: Address:
	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.

Doctor's Signature & Stamp	Date:	Regn No:	
Doctors Name:			
Address:			

16. What is the Prognosis?