

## CLAIM FORM - LOAN GUARD

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

- a) Claim form is to be filled in capital letter & signed by the insured/claimant.
- b) Please do not leave any column unanswered.
- c) Please read carefully the attached list of documents required to speed up processing of your claim.
- d) If there is insufficient space, kindly use a separate sheet which can be attached to this form.

		Claim Number:
DETAILS OF INSURED		
Name of the Insured		
Name of the Claimant	First Name Middle Name	Last Name
Traine of the claimant	First Name Middle Name	Last Name
Relationship with Insured	Designation (If applicable	:)
Date of Birth	DMMYYYY Sex: Male Fem	nale
Email ID		
Communication Address		
	y/Taluka District District	
Stat		STD code
Pho	one No Mobile Mobile	
DETAILS OF INSURED		
Policy No		
Period of insurance from	mtoSum Insured	
DETAILS OF OTHER POLIC	Y	
	er any Policy of any other insurance companies? Yes No	)
If yes please enclose photoco		
	ery first insurance for the from           to	
Beneficiary with continuous in	nsurance coverage	
BENEFITS		
Section 1 – Critical Illness: ( *please refer policy document		
1 star Plan	2 Star Plan 3 Star Plan	4 Star Plan
Section II - Personal Accider	nt 🗌	
A. Death Due to an Accid	dent: B. Permanent Total D	isability due to an Accident:
DETAILS OF INCIDENCE		
Nature of Disease / Illness /	/ Injury	
Cause of Disease / Illness /	Injury	
Date of incidence	Date of incidence  DDMMYYYY Time of incidence : AM/PM	
Place of incidence		
Incidence Reported to		
Are there any witness to incidence Yes No		
Names and Address of witn	iesses	





DETAILS OF HOSPITAL	APPLICABLE FOR SECTION I & II		
Was the insured person r	moved to hospital immediately after the incidence Yes No		
If yes, please fill in the fo	llowing		
Date of admission	Time of admission : AM/PM.		
Date of discharge	Time of discharge : AM/PM.		
Name of the Hospital			
Address			
	City/Taluka District District		
	State Pin Code STD code		
	Phone No Mobile Mobile		
	Mobile		
Particulars of treatment			
MEDICAL PRACTITION	er's declartion applicable for section i & ii		
I hereby certify that	was treated		
by me on	for for which first		
incurred on			
	son who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially eading information may be subject to prosecution for insurance fraud.		
Details			
Name of the treating			
J	First Name Middle Name Last Name		
Medical Practitioner			
Registration No	Qualification		
Data:	Clause and Clause wa		
Date:	Stamp and Signature  of the Medical practitioner		
Place:	of the Medical practitioner		
Section III – Loss of Job			
Loan Details:			
Loan A/c No: -			
Name & Address of			
Bank / Institution			
Contact Details (Phone / E-Mail)			
Type of loan taken	Date of inception of repayment		
Amount of loan taken	Loan Balance as on date		
Last Month for repaymen	at		
Employer Details:			
Name of Organization e	mployed Till Till Till Till Till Till Till Til		
Address			
, wai 033	Control pumpers of the Control of th		
Б : :	contact numbers of the Company in which employed		
Designation			
Date of appointment	Date of confirmation:		
Nature of employment	Permanent probation casual temporary seasonal contractual		
Date of termination	suspension retrenchment		



## LOAN GUARD - CLAIM FORM

Last wa	orking day	Last salary after termination / suspension Rs.			
Period of suspension if applicable Amount drawn during suspension period Rs.					
Date of	re-employment and details:				
	ner relevant details : (Please attach sepa	rate sheet if necessary)			
Please	attach the following documents with the	completed claim form			
1. C					
er of	Certificate from the employer of the Insured person confirming the termination, dismissal, temporary suspension or retrenchment from employment of the Insured person furnishing the date of termination, dismissal, temporary suspension or retrenchment from employment of the Insured person with the reasons for the same. In case of temporary suspension the period of suspension should also be mentioned in such certificate				
3. Ap	ppointment and confirmation letter of er	mployment.			
	n IV – Fire and Allied Perils – Dwelling refer to Annexure A)	and Household Contents			
	n V- Business Interruption(Applicable for refer to Annexure B)	or Commercial Establishments)			
DETAI	LS OF CLAIMED AMOUNT				
		Description	Amount (Rs.)		
(A)	Critical Illness				
(B) i	Death				
(B) ii	Permanent Total Disability				
(C)	Loss of Job				
(D)	Fire and Allied Perils – Dwelling and H	ousehold Contents			
(E)	Business Interruption  AMOUNT CLAIMED				
IOIAI	LAMOUNI CLAIMED				
ENCL	OSURES				
Cla	im form duly signed	Policy copy	Claim intimation		
FIR,	/ MLC copy	Death certificate	Post mortem report		
Inq	uest / Coroner's report	Final police report	Disability Certificate		
Inve	estigation reports	Medical certificate	Nominee certificate		
Em	ployer Certificate	Photograph of the injured with reflecting disableme	nt		
Any	other documents				
If yes p	lease specify:				
Any oth	ner information You wish to state:				
INSU	RED'S /CLAIMANT'S DECLARATION				
		nt and sincerely declare that I have not suppressed or conce n/s may result in Magma General Insurance Limited being			
Magma		ng / related document does not constitute or be deemed and Magma General Insurance Limited reserves the right 			
Date:	D D M M Y Y Y Y	Signature of Claimant:			
Place:		Name of the Claimant:			



## LOAN GUARD - CLAIM FORM

TO BE COMPLETED BY NOMINEE IN THE EVENT OF INSURED'S DEATH				
Name of the Nominee:	First Name Middle Name Last Name			
Relationship with Claim	ant:			
Date of Birth: DDMMYYYY Sex: Male Female Email ID:				
Communication:				
Address:				
City/Taluka:	District: State:			
Pin Code:	STD code: Phone No.:			
	Mobile:			
*If nominee is minor, kindly provide the Legal Guardian details				
	First Name Middle Name Last Name			
Name of the Guardian:				
Address:				
City/Taluka:	District: State:			
Pin Code:	STD code: Phone No.:			
	Mobile:			
Date of Birth:	DDMMYYYY Sex: Male Female			
I/We hereby declare and warrant the truth of the foregoing particulars in every respect. I /We agree that if I/We have made orshall make false or untrue statement, suppression or concealment, my/our right to compensation shall be forfeited. I/We also hereby declare that I am/we are accepting the amount in full discharge of your obligations under the policy to the Insured Person and /or his/her legal heirs. I/we will hold you indemnified in the event of any claim under this policy being made against you by any other person or persons.				
Date: DDMMYY	Signature of Nominee:			
Place:	Name of the Nominee:			