Office Package Insurance Policy (Retail)

Section 8: Personal Accident Insurance Claim Form

Claim No._____
Policy No._____

All questions must be answered fully. If there is insufficient space, kindly use a separate sheet which can be attached to this form. If any section is not fully completed or left blank, the form will be returned for completion.

The issue or acceptance of this form is not to be construed as an admission of liability by MHDI.

A. The Insured

Name _____

Address_____
_____

Tel No. Office_____ Mobile_____ email _____

B. Policy Details

Policy No._____Period of Insurance _____ to _____

C. Claimant/Deceased Details

Name _____

Sex Male □ Female □

Date of Birth _____/_____/_____

Occupation_____

Relationship with Insured_____

Employee/Member identification number (for group policies) _____

Address where a representative on behalf of MHDI can visit _____
_____

D. Accident Details

Date of accident (dd/mm/yy)_____/_____/_____
Time of accident _____ am/pm

Did it occur at work Yes □ No □

Where did the accident occur_____

How did the accident happen

_____
_____
_____

Was the accident reported to Police Yes □ No □
If not, kindly state the reasons

_____
_____

Are there any witnesses to the accident Yes □ No □
If yes, kindly provide name(s) and contact details

_____
_____

Describe the nature of injuries received

_____
_____

Period of disability

Total disability- confined to Bed
(dd/mm/yy)_____/_____/_____ to_____/_____/_____

Partial disability – confimed to House
(dd/mm/yy)_____/_____/_____to_____/_____/_____

If partially disabled, kindly state the daily duties of usual occupation which cannot be performed_____

E. Hospitalisation/treatment Details

Name & contact details of doctor first consulted after the accident_____
_____

Name and contact details of other doctors consulted_____
_____

_____

Name and contact details of claimant's usual medical practioner

_____

_____

Whether hospitalized following the accident Yes □ No □
If yes, name & address of hospital

_____

Period of hospitalization
(dd/mm/yy)_____/_____/_____ to_____/_____/_____

F. Other Insurances

Details of any other insurance (arranged by self, spouse, parents or employer) under which claimant/deceased is covered

Name of insurer	Policy Number	Period of insurance	Coverage	Sum insured

G. Claim Amount

I hereby warrant the truth of foregoing statement and sincerely declare that I have not suppressed or concealed any information that is material to this claim. I understand that false declarations may result in MHDI being able to refuse to pay a claim.

I authorize any hospital, physician or any other medical provider who has attended me or examined me to furnish MHDI such details of my medical history/treatment as they may require.

Signature of Insured/claimant
Date

Documents to be attached to the claim form:

-
-

Medical Attendant's Certificate

Name of patient _____
Occupation_____

How long have you known this patient _____

Are you his/her usual Medical Attendant Yes □ No □

Kindly state the nature of and extent of injuries

Is the injury consistent with patient's description of the accident
Yes □ No □

Are the injuries connected with any previous accident, infirmity or disease
Yes □ No □
If yes, please provide details

Will the recovery be retarded due to above Yes □ No □
If yes, kindly provide details

When were you first consulted for this injury/disability (dd/mm/yy)_____/_____/_____

Please give details of other consultations – Dr's name,
address

Are you still treating the patient for the injury/disability Yes □ No □

Kindly provide details of treatment prescribed

If X-ray has been done, kindly state the findings and Radiologist's report

If hospitalized, name of hospital

Period of hospitalization (dd/mm/yy)_____/_____/_____ to_____/_____/_____

Date & Nature of surgical procedure, if any (dd/mm/yy)_____/_____/_____.

Are there any complications which may retard the recovery

Has the patient suffered from similar injury/disability previously? Yes □ No □

_____

If yes, when, nature and duration of the

_____

_____

Was the patient under the influence of intoxicants or drugs at the time of accident
Yes □ No □

While under your care and direction, how long was or will the patient be:

a)Totally unable to perform each and every duty of his/her usual occupation
From (dd/mm/yy)_____/_____/_____ to_____/_____/_____

b) Partially disabled from performing his/her usual occupation
(dd/mm/yy)_____/_____/_____ to_____/_____/_____

Nature of disablement (in case of permanent disability)
Permanent Total disability

_____

Permanent partial disability

_____

Prognosis Please comment on any additional factor that may prolong recovery from injury/disability

_____

_____

I certify that I have personally attended to the named above patient and the above statements are correct.

Signature* Qualification Reg.No.

Name Address

Date

*Kindly Affix official seal/stamp