



## Accidental Injury Claim Claimant's Statement

Form 'A'

### INSURED INFORMATION

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Marital Status \_\_\_\_\_  
Insured's Address \_\_\_\_\_ Phone No. (Off) \_\_\_\_\_  
\_\_\_\_\_ Phone No. (Res) \_\_\_\_\_  
Name and address of employer \_\_\_\_\_  
Policy Number \_\_\_\_\_ Insured's Occupation \_\_\_\_\_  
Does the insured have any other insurance? \_\_\_\_\_ If yes, please list all companies, type of insurance, policy numbers and insurance amounts: \_\_\_\_\_  
\_\_\_\_\_

### CLAIM INFORMATION

Date of accident \_\_\_/\_\_\_/\_\_\_ Time and place accident occurred \_\_\_\_\_  
Please describe in detail the circumstances of accident (attach separate sheet if needed): \_\_\_\_\_  
\_\_\_\_\_  
Was the accident related to the Insured's occupation? \_\_\_\_\_ If so, how? \_\_\_\_\_  
Please describe the nature of Insured's injuries: \_\_\_\_\_  
Please list the names and addresses of all treating physicians and hospitals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Did police or other authorities investigate the accident? \_\_\_\_\_ If yes, please provide name, address and telephone number of all investigating officers and agencies: \_\_\_\_\_  
\_\_\_\_\_

### CLAIMANT INFORMATION (If different than "Insured Information" above)

Claimant's Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship to Insured \_\_\_\_\_  
Claimant's Address \_\_\_\_\_ Phone No. (Off) \_\_\_\_\_  
\_\_\_\_\_ Phone No. (Res) \_\_\_\_\_  
In what capacity are you making this claim? \_\_\_\_\_

### AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by HDFC ERGO General Insurance, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Claimant or authorized person) \_\_\_\_\_ DATE \_\_\_/\_\_\_/\_\_\_