Note: CLAIM FILE SHOULD BE SUBMITED WITHIN 10 DAYS ELSE ON LATE SUBMISSION ON CLAIM MAY BE REJECTED

- 1. Claim Form
- 2. Doctor's Medical Certificate
- 3. Sign on Claim Form of Policy Holder
- 4. One original cancelled cheque with name printed on cheque or first page of Passbook
- 5. Total Claim Amount: Rs._____
- 6. Photo Copy of Policies (One Year or Two Year)
- 7. Discharge Card / Summary
- 8. Fitness Certificate
- 9. Hospital Payment Receipt with Revenue Stamp
- 10. All Prescriptions attached with related bills signed & stamped by the Doctor on back
- 11. Lab Reports (if any)
- 12. Films & Report of X-ray / Sonography
- 13. Form "C" of Hospital Registration
- 14. Full set Xerox of claim file for your record
- 15. Copy of Aadhar Card & Pan Card with Self attested of policy holder & Patient Person
- 16. Last Three years Income Tax Return



Regd. Office: Bombay Pune Road, Akrudi, Pune 411 035 & Head Office: GESCO Plaza, Airport Road, Yerawada, Pune 411 006

PERSONAL ACCIDENT INSURANCE

CLAIM FORM

Policy	Claim No.							
No	Date of reg	gistration						
Regional/Branch Office Code								
Broker/Agent			Code	e				
 Name of the Insured Customer ID 								
3. Address of the Insured	Plot No/ No.	Door	Building name					
	Road		•					
	Area							
	City		Pin code					
	State							
	Phone No.							
	E-mail Id							
4. Profession or Occupation								
Policy details								
Sum Insured	Table of C	over						
 5. a)Name of the insured persinjured in the accident b) Relationship with the c c) Employee/member ide 6. a) Date of the Accident b) Time of the Accident c) Where it happened? d) Name & Address of the 7. How did the Accident occ 	employee/ member ntification no.	Self/Spou	se/Children					
8. Nature of Injury received Eye state whether right or								
9. a) Nature of disablement								
b) Extent of disablement								
c) Period of temporary total disablement		(Fromto)						
d) Present state of incapac	eity							

Bajaj Allianz General Insurance Co. Ltd



10. Name and address of Surgeon in attendance
11. Where and when can a Medical Officer
of our Company visit you, if
necessary?
12. a) Are you insured in any other Office or
Offices granting compensation for
accident?
b) If so state name and address of company or
Companies and amount of Insurance
I/We hereby declare that the foregoing statements are true in all respects and that I/We have not
attempted to conceal from the company anything with which it ought to be made acquainted and
also that if I/We have made or in any further declaration the Company may require shall make
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attempted to conceal from the company anything with which it ought to be made acquainted and also that if I/We have made or in any further declaration the Company may require shall make any false or fraudulent statement or any suppression, concealment or untrue averment whatever, the Policy shall be void and my/our right to compensation forfeited and am/are willing if required, to make a statutory Declaration before a Justice of the Peace of the truth of the whole of the foregoing statement or any other statement I/We may make in connection with this claim.

Witness: Name		
Signature		
\otimes		
Signature of the Insured	Date	



MEDICAL CERTIFICATE

(Claim must be supported by the Me	Evidence furnished by	the Insured at his/her expense)
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1. a) Name of Claimant

(b) Age

- 1. a) Nature and cause of Accident
 - b) If to eye or limb, state left or right
 - c) Whether the appearance of the injuries are consistent with the account given of the accident
- 2. Date on which you first attended claimant for this injury
- 3. Has claimant been totally prevented from attending to any portion of his business? If so for how long?
- 4. Is claimant suffering from any disease or illness apart from his injury and is there any illness by circumstances which may tend to retard recovery? If so, give particulars
- 5. Present condition
- 6. How long from the happening of the Accident do you consider
 - a) Total disablement will last
 - b) Partial disablement will last

Having personally examined the above named Insured, I certify that the above statements are correct and that the injured person is necessarily disabled by the accident referred to.

Signature:

Name:

Qualification:

Address:

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િલ્ Bajaj Allianz General Insurar	nce Company Lt	d								
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	(As appears in	your banl	k acco	ount)	1		*	-		
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						PIN	Code	:		
Contact / Mobile No:		Email ID):							
Bank Name:										
Branch Name & Address:					w					
Branch IFS Code for NEFT							T			
Name of the Account Holder : (As per Bank Account)				-						
Account Type	Savings			Curr	rent			Casi	n Credi	t
Account No. (as appearing in the cheque book)										
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