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

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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