MAGMA
General Insurance Limited

CLAIM FORM - INDIVIDUAL PERSONAL ACCIDENT POLICY

Issue of this Claim Form is not to be taken as an Admission of Liability

Toll Free No. 1800 266 3202

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.

Claim Number_____

A. THE INSURED:

Name

Address:

City: State: Pin:

Phone: Mobile:

Email ID:

B. POLICY DETAILS:

Policy Number _____ Period of Insurance : From D D M M Y Y Y Y To D D M M Y Y Y Y

C. CLAIMANT/DECEASED DETAILS:

Name

Sex ☐ Male ☐ Female Date of Birth D D M M Y Y Y Y

Occupation _____ Relationship with Insured _____

Address where a representative on behalf of **Magma General Insurance Limited** can visit

D. ACCIDENT DETAILS:

Date of accident D D M M Y Y Y Y Time of accident H H : M M 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? If not, kindly state the reasons	Yes ☐ No ☐
Are there any witnesses to the accident? If yes, kindly provide name(s) and contact details	Yes ☐ No ☐
Was Post-mortem conducted? If yes, kindly attach a copy of the Report	Yes ☐ No ☐
Describe the nature of injuries received.	
Period of disability Total disability-confined to Bed Partial disability – confined to House	From D D M M Y Y Y Y To D D M M Y Y Y Y From D D M M Y Y Y Y To D D M M Y Y Y Y
If partially disabled, kindly state the daily duties of usual occupation which cannot be performed	

E. HOSPITALIZATION / 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 practitioner	
Whether hospitalized following the accident If yes, name & address of hospital	Yes ☐ No ☐
Period of hospitalization	From D D M M Y Y Y Y To D D M M Y Y Y Y

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 **Magma General Insurance Limited** 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 **Magma General Insurance Limited** such details of my medical history/treatment as they may require.

Date D D M M Y Y Y Y

Signature of Insured/claimant

Documents to be attached to the claim form:

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-

Medical Attendant's Certificate

Name of patient	
Occupation	
How long have you known this patient?	
Are you his/her usual Medical Attendant? Kindly state the nature of and extent of injuries	Yes ☐ No ☐
Is the injury consistent with patient's description of the accident?	Yes ☐ No ☐
Are the injuries connected with any previous accident, infirmity or disease? If yes, please provide details	Yes ☐ No ☐
Will the recovery be retarded due to above? If yes, kindly provide details	Yes ☐ No ☐
When were you first consulted for this injury/disability?	D D M M Y Y Y Y
Please give details of other consultations – Doctor's name Address	
Are you still treating the patient for the injury/disability Kindly provide details of treatment prescribed	Yes ☐ No ☐
If X-ray has been done, kindly state the findings and Radiologist's report	
If hospitalized, name of hospital	
Period of hospitalization	From D D M M Y Y Y Y To D D M M Y Y Y Y
Date & Nature of surgical procedure, if any	D D M M Y Y Y Y
Are there any complications which may retard the recovery:	
Has the patient suffered from similar injury/disability previously? If yes, when, nature and duration of the treatment	Yes ☐ No ☐
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 b) Partially disabled from performing his/her usual occupation	From D D M M Y Y Y Y To D D M M Y Y Y Y From D D M M Y Y Y Y To D D M M Y Y Y Y
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 D D M M Y Y Y Y

*Kindly Affix official seal/stamp