

Claim 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 Magma General Insurance Limited.

A. The Insured

Name																														
Address																														
City							State							Pin Code																
Tel No. Office							Mobile																							
E-mail																														

B. Policy Details

 Policy No. _____ Period of Insurance _____ to _____

C. Claimant/Deceased Details

Name																															
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	____/____/____																											
Occupation	_____															Relationship with Insured	_____														
Address where a representative on behalf of Magma General Insurance Limited 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 _____

 Was Post-mortem conducted Yes No If yes, kindly attach a copy of the Report

Describe the nature of injuries received _____

Period of disability

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

Partial disability – confined to House (dd/mm/yy) ____/____/____ to ____/____/____

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																														
Address																														
City							State							Pin Code																
Tel No. Office							Landline							Mobile																
E-mail																														

Name and contact details of other doctors consulted

City		State		Pin Code	
Tel No. Office		Landline		Mobile	
E-mail					

Name and contact details of claimant's usual medical practitioner

City		State		Pin Code	
Tel No. Office		Landline		Mobile	
E-mail					

 Whether hospitalized following the accident Yes No

If yes, name & address of hospital

City		State		Pin Code	
Tel No. Office		E-mail			

Period of hospitalization (dd/mm/yy) ___/___/___ to ___/___/___

F. Details of Dependent Children (For claim under Education Grant Benefit)

Name of Dependent Child	Age of Dependent Child	Education Pursuing	Name of School/ College/Institute

Documents required:

- 1) Admission card
- 2) ID card
- 3) Last year's Mark sheet
- 4) Letter from school, college, institute affirming he/she is studying in their organization.

G. 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

