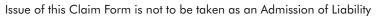
CLAIM FORM - ONEPROTECT



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 C. CLAIMANT/DECEASED DETAILS: Name Male Female Date of Birth Sex Occupation Relationship with Insured Address where a representative on behalf of Magma General Insurance Limited can visit D. ACCIDENT DETAILS: Time of accident Date of accident Did it occur at work? Yes No Where did the accident occur? How did the accident happen? Was the accident reported to Police? Yes 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 From Total disability-confined to Bed Partial disability – confined to House From If partially disabled, kindly state the daily duties of usual occupation which cannot be performed





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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 No				
Period of hospitalization		From DDMMYYYY To DDMMYYYY				
F. OTHER INSURANCES:						
Details of any other insurance (arranged	by self, spouse,	parents or emplo	yer) under which	claimant/dec	eased is covered	
Name of insurer	Policy Number		Period of ir	surance	Coverage	Sum insured
In case of any claim payout, ID & Addres	ss proof needs to	be submitted for	KYC purpose.			
G. CLAIM AMOUNT:	_	_	_	-	_	
I hereby warrant the truth of foregoing sta this claim. I understand that false declarat						
I authorize any hospital, physician or any Limited such details of my medical history/	other medical p	orovider who has		_		
Date DDMMYYYY			_	Signature of Insured/claimant		



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Documents to be attached to the claim form:

Medical Attendant's Certificate

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?	DDMMYYYY	
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 DDMMYYYY To	D M M Y Y Y Y
Date & Nature of surgical procedure, if any	DDMMYYYY	
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 DDMMYYYY To I	
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	o the named above patient and the above	re statements are correct.	
Signature*	Qualification	Reg. No	
Name:			
Address			
Date DDMMYYYY			
		*Kindly Affix official se	al/stamp

Magma General Insurance Limited (erstwhile Magma HDI General Insurance Company Limited) | www.magmainsurance.com | E-mail: customercare@magmainsurance.com | Toll Free: 1800 266 3202 | Registered Office: Development House, 24 Park Street, Kolkata – 700016, West Bengal. | CIN: U66000WB2009PLC136327 | IRDAI Reg. No. 149 | OneProtect | Product UIN: MAGPAIP25036V012425 | For complete list of details on exclusions, risk factors, terms & conditions, please read the policy documents carefully before concluding a sale. | Trade Logo displayed above belongs to Magma Ventures Private Limited and is used by Magma General Insurance Limited under license. | Chat with MIRA on our website or say "Hi" on WhatsApp No. 7208976789 (CF.OP.ver10.12.24)