Liberty General Insurance

Liberty Group Personal Accident Policy Claim Form

Basic Information

Policy No: Claim No:
Insured Name:
Insured Person Name:
Claimant Name:
Relationship:
Address:

City Pin ode

Contact No: Residence Office: Mobile:

Occupation DOB

Accident Details

Date of Accident
Time of Accident
Place & Location:
Description of accident/Incidence:

Details of injuries sustained

Specify injured parts of the body:

Please specify nature of Disability:

Please mention Disability percentage in case of Permanent partial disablement, certified by Doctor: %

Witnesses

Name:
Address:

Contact No: Residence Office: Mobile:

Tick Against the Section Claimed for:

Liberty General Insurance

Basic Cover:	Death	PTD	PPD	TTD

Extension Covers:	Child Education Support	Performance of Funeral Ceremony
	Transportation of Mortal Remains	Modification of Vehicle / Residence
	Accidental Medical Expenses	Family Transportation Benefit
	Accidental Hospital Daily Cash	Outstanding Bills Protection Benefit
	Life Support Benefit	Ambulance Hiring Charges
	Loan Protector	Legal Bail Expenses
	Broken Bone	Double Indemnity
	Evacuation Expenses	

Treatment Details

Casualty Doctor	Name: Address: Tel Nos:
Family Doctor	Name: Address: Tel Nos:
Hospital Details	Name: Address: Tel Nos:

Confinement

Inpatient treatment From *dd/mm/yyyy* To *dd/mm/yyyy*

Outpatient treatment From *dd/mm/yyyy* To *dd/mm/yyyy*

Total Confinement: From *dd/mm/yyyy* To: *dd/mm/yyyy*

(This should be the actual days when fully confined to bed on Medical Advice)

Details of medical expenses:

Date:	Receipt No	Particulars	Amount

Please attach separate sheet for additional bills / receipt details

Policy and Claims History:

A) Have you made any Claims in Past? Yes
No
B) If YES, Please give details including nature of Accident, Insurance details & Claim amount

C) Are you insured under any other Policy? Yes
No
If YES, Please give full particulars

Name of Company	Policy No	Policy Period	Policy Issuing Office

Declaration I/We agree to provide additional information to the company, if required. I/We the above mentioned, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and if I/We have made, or in any further declaration the company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, the policy shall be void and all rights to recover there under in respect of past or future accident shall be forfeited. I hereby consent to Liberty General Insurance Limited approaching my doctor for all information that it deems to be necessary

Place

Date

Sign/ Thumb Impression of the Insured/ Insured Person

Liberty General Insurance

Attending Physician Statement

(To be filled by the Treating Doctor)

Name & Age of the Insured Person	
Address	
Nature of the Accident	
Details of the Injuries sustained	
Does the Cause of Accident as stated by the Claimant tally with the Injuries noticed by you?	Yes No
Are the injuries solely due to the accident If No, Please provide the details:	Yes No
Was the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition	Yes No
Was the claimant hospitalized? If so for what period?	From To
What treatment was given and operations performed?	
Give all dates of treatment:	Clinic/Hospital: From To Home: From To
Was he/she under the influence of intoxicants or drugs at the time of accident?	Yes No
Are you his family doctor?	Yes No
Please give the details, If you have treated him for any previous illness or injury?	
Have other Doctors been in Attendance or Consultation? If Yes, Please give the details	Yes No
Has this accident been reported to the Police Authorities? If Yes, then please provide	Yes No Case No: Police Station:
Is this claimant Totally Disabled from each and every occupation?	Yes No
How long was or will the claimant be totally disabled from current occupation?	From To
How long was or will the claimant be partially disabled from current occupation?	From To
Estimated date of return to Work	Date: dd/mm/yyyy
What is the Prognosis?	
Doctor's Name	
Qualification	
Address	
Tel No	
Registration No	
Signature	

Date: ……. Signature and Seal of the Doctor / Hospital

In case of Personal Accident Death claims

a) FIR from police authorities wherever necessary (in case of accidents outside residence)
b) Death Certificate from the Municipal Authorities
c) Death Summary from the Hospital Authorities if death is confirmed by the Hospital
d) Post Mortem Report, if conducted
e) Documentary proof of accidental death
f) Duly filled and signed claim form
g) Policy Copy and Annexure
h) Inquest / Panchnama Report
i) Photographs of the insured
j) Coroner's Report
k) Letter from HR stating the attendance closure to the incident

In case of Personal Accident Permanent Partial and Total Disability claims

a) FIR from police authorities wherever necessary (in case of accidents outside residence)
b) Medical Certificate from the attending Medical Practitioner for the injury indicating the extent of disability
c) Duly filled and signed claim form
d) Policy Copy and Annexure
e) Hospital / Nursing Home Medical Records
f) Leave certificate from HR (for salaried people)
g) Salary certificate / income proof
h) Photographs of the insured showing affected area

In case of Personal Accident Temporary Total Disability claims

i) FIR from police authorities wherever necessary (in case of accidents outside residence)
j) Medical Certificate from the attending Medical Practitioner for the injury indicating the extent of disability
k) Medical fitness certificate from the Treating consultant indicating duration of rest medically advised
l) Duly filled and signed claim form
m) Policy Copy and Annexure
n) Hospital / Nursing Home Medical Records
o) Leave certificate from HR (for salaried people)
p) Salary certificate / income proof
q) Photographs of the insured showing affected area

In case of claim under other covers:

Child Education Support:

- Proof of number of dependent children viz. Ration card
- Age proof of the dependent children

- Bills and receipt towards cost of transportation of the mortal remains to the place of residence/hospital and/or cremation/burial ground.

- Bills and receipt towards expenses relevant to funeral ceremony.

Accidental Medical Expenses

- Copy of document of hospitalization/medical treatment
- Certificate from treating doctor about the diagnosis and line of treatment given during hospitalization/medical treatment.
- Hospital / Nursing Home Medical Records, when required for verification of claims
- Bills and receipts towards medical expenses.
- Copy of the test reports

- Copy of document of hospitalization
- Certificate from treating doctor about the diagnosis and line of treatment given during hospitalization

- Loan documents from financial institution/s

Life Support

- Permanent Total Disability related documents
- Bill and receipts towards Life support expenses

Broken Bone

- Bills and receipts towards medical expenses
- Copy of the test reports
- X Ray plates reflecting broken bones

Modification of Vehicle / Residence

- Bills and receipts towards vehicle or residence modifications

Family Transportation Benefit

- Bills and receipts towards travel expenses of family member/s

Outstanding Bills Protection Benefit

- Proof of outstanding Bills

Ambulance Hiring Benefit

- Bills and receipt towards cost of ambulance services

Legal Bail Expenses

- Notice & Receipts of the bail expenses incurred.

Double Indemnity

- Proof of travel through public transport and subsequent accident**.**

Evacuation Expenses

- Certificate from licensed physician about the diagnosis
- Bills and receipts towards evacuation expenses

We may ask for additional requirement in certain peculiar cases as per the nature of claim.