

**Bharti AXA General Insurance Company Limited** 

**1800-103-2292** 

- claims@bharti-axagi.co.in
- SMS <CLAIM> to 5667700

## SmartPersonal Accident - Individual Insurance Claim Form

Important Note	
Issuance of this form not to be taker	as an admission of liability
	and <b>Tick the Boxes</b> where appropriate and do not leave any column unanswered.
Part - I	
Policy Number:	Claim Number:
Period of Insurance: DDMMYYY	Y Y  to  D D M M Y Y Y  INS ID No.:
1 Insured details	
Name of the Insured:	
Address	
	City
Pin code	State
Contact Nos. Mobile No.	Office +91
Residence +91	E-mail ID
For Group Policies:	
Corporate Name	Employee Code
2 Injured/deceased details:	
Name of the Insured/Deceased	Gender: Male Female
Relationship with the Insured	
3 Claim details:	
Date of Accident D D M M Y	$Y \mid Y \mid Y$ Time of Accident $H \mid H \mid M \mid M$ (Kindly provide exact location of accident)
Place of Accident	
Witnesses, if any Brief narration of a	codent:
Miles the ex EID (i) and a	No. If you FID No.
Whether FIR filed? Yes Police Station	No If yes, FIR No.
If no, please state reasons for not in	nforming police:
, p	
Name of attending Doctor/Physician	
	(Please attach a report from the attending physician in attached format)
Name of Hospital, where admitted/treated	
Address of Hospital	

	ole only in injury cases)	IIS WII	ere our represer	itatives/ boctor	could examine ti	e injuieu.	
Date of a	admission DDDMMYYYYYY	Dat	e of discharge:	DIDIMIMIY	′		
Nature of	f Claim: Non-fatal Injury F	atal lı	njury				
Non-fatal Injury:	a) Nature of Injury b) Nature of disablement						
	c) Extent of disablement						
	•	ont.		(Percentage of dis	sability as assessed b	y the attending doctor)	
	<ul><li>d) Period of temporary total disablem</li><li>e) Total period of confinement: From</li></ul>	DID	- M - M - Y - Y - Y	′	MIMIYIYIY	(From the date of	
Fatal Inju				10 0 0		accident till recovery	
	Post Mortem: Date conducted			′ <sub> </sub> Y			
	Hospital where conducted						
	of claim (Please mention & include und				Medical expenses	, funeral expenses,	
	nal grant etc. & attach separate sheet	if the	space is insuffi				
SI. No.	Details			Bill No.	Date	Amount (Rs.)	
_				_	Tota		
-	currently insured under any other accidently complete the following table.	ent in	surance policies	?	Yes No		
SI. No.	Name & address of Insurance Company	From	То	Sum Insured (Rs.)			
	, ,		Policy No.			,	
Please fu	urnish the following list of documents:						
	Discharge Summary in full		FIR	Post	mortem report		
Α	All prescriptions along with medical rep	orts	All hospita	l/drug bills & re	ceipts in original		
	Attached physician's statement duly completed by him/her				to ID card (PAN, I assignee (in deat	DL, Ration Card etc.) h claims)	
4 Insu	red's / patient's consent for acces	ss to	medical record	ls & declaratio	n		
records pe authorised	by authorize Bharti AXA General Insurance ertaining to the above patient available with dagency engaged by them may be allowed the charges will be borne by the Insurance Co. co	n any h ed acce	ospital/doctor. These & possession	e Insurance Com of medical reco	pany or their repres	entatives or any othe	
and belief, may requir	e to provide additional information to the Cor , warrant the truth of the foregoing statemer re in respect of the said accident, shall make old and all rights to recover thereunder in resp	nt in ev ke any	ery respect, and if false or fraudulen	I/We have made, t statement, or ar	or in any further de ny suppression or co	claration the Company	
Date:	PI	ace:_				-6 lu 1/A	
					Signature	of Insured/Assignee	





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Please fill this form in Block Letters	and Tick the Boxes	where approp	oriate and do i	not leave any	column unanswered.									
If any detail or information is not read sent later.	dily available, please do	not delay despa	atch of this re	port and suc	h particulars may be									
Part - II: Attending physician's s	tatement													
Name of the Injured/Deceased														
	Age Years	Gender:	Male	Female										
Address														
		City												
Pin code		State												
Date when injured was brought to yo Diagnosis:	u first: DIDIMIMIY	Y   Y   Y												
Please provide previous medical hist	ory of the injured:													
Is the present condition/disability at	tributable to conginetal c	lefect? If yes, pl	lease provide (	details:										
Nature of the accident and details of	injuries sustained:													
Are the injuries solely due to the acc	ident or traceable to any	previous injurie	es/disease/inf	firmities?										
Nature of treatment/surgery perform	ed for present illness/di	sease/injury:												
Was injured/deceased under the infl If yes, please provide details of diag	luence of intoxicants or one of the control of the	drugs at the time content.	e of accident?											
Are you his/her usual medical attended	dant? If yes, please give	detailsof previo	us treatment f	or any illness	s/disease/injury:									



Attending Doctor's Name																				
Registration No.																				
Address																				
					Ci	ity														
	Pin code				St	tat	е													
Telephone No.																				
Date:											-	Doc	cto	r's	Sig	gna	atur	re		

Insurance is the subject matter of the solicitation.

