Liberty General Insurance Limited
10th Floor, Tower A, Peninsula Business Park,
Ganpatrao Kadam Marg, Lower Parel, Mumbai - 400 013
Phone: +91 22 6700 1313 Fax: +91 22 6700 1606
Email: care@libertyinsurance.in
IRDA registration number: 150 ● CIN: U66000MH2010PLC209656

LIBERTY INDIVIDUAL PERSONAL ACCIDENT POLICY CLAIM FORM

Basic Information

Policy No. : Claim No. :

Insured Name :

Insured Person Name :

Claimant Name :

Relationship :

Address :

City : Pin Code :

Contact No. : Residence : Office : Mobile :

Occupation : Date of Birth : d d m m y y y y

ABHA Id :

'If ABHA ID is not available, we urge you to visit https://abdm.gov.in/ for creation of ABHA ID and inform the same to us once created.'

Accident Details

Date of Accident : d d m m y y y y Time of Accident : h h m m

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 :

City : Pin Code :

Contact No. : Residence Office : Mobile :

Tick Against the Section Claimed for

Basic Cover : ☐ Death ☐ PTD ☐ PPD ☐ TTD

Extension Covers :

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

Treatment Details

Casualty Doctor

Name :

Address :

Tel No. :

Family Doctor

Name :

Address :

Tel No. :

Hospital Details

Name :

Address :

Tel No. :

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Confinement

Inpatient Treatment : From d d m m y y y y To d d m m y y y y

Outpatient Treatment : From d d m m y y y y To d d m m y y y y

Total Confinement : From d d m m y y y y To d d m m y y y y

(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 Ltd. approaching my doctor for all information that it deems to be necessary.

Place : _____

Date : d d m m y y y y

_____
Sign / Thumb Impression of the Insured / Insured Person

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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 d d m m y y y y To d d m m y y y y
What treatment was given and operations performed?	
Give all dates of treatment	Clinic / Hospital : From d d m m y y y y To d d m m y y y y Home : From d d m m y y y y To d d m m y y y y
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 d d m m y y y y To d d m m y y y y
How long was or will the claimant be partially disabled from current occupation?	From d d m m y y y y To d d m m y y y y
Estimated date of return to Work	Date : d d m m y y y y
What is the Prognosis?	
Doctor's Name	
Qualification	
Address	
Tel No.	
Registration No.	
Signature	

Date : d d m m y y y y

_____
Signature and Seal of the Doctor / Hospital

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Check List of Indicative Documents to be submitted for Individual Personal Accident Claims

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. Legal Heir/Succession Certificate
g. Duly filled and signed claim form
h. Policy Copy and Annexure
i. Inquest / Panchnama Report
j. Photographs of the insured
k. Coroner's Report
l. 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

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. Medical fitness certificate from the Treating consultant indicating duration of rest medically advised
d. Duly filled and signed claim form
e. Policy Copy and Annexure
f. Hospital / Nursing Home Medical Records
g. Leave certificate from HR (for salaried people)
h. Salary certificate / income proof
i. Photographs of the insured showing affected area

In case of claim under other covers

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

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

Cost of Performance of Funeral Ceremony
- Bills and receipt towards expenses relevant to funeral ceremony.

Child Education Support Benefit
- Proof of number of dependent children viz. Ration card
- Age proof of the dependent children

Accidental Hospitalisation 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

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

Loan Protector
- 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.

You are requested to send the claim documents at below address:

Liberty General Insurance Limited, The Capitol, 2nd and 3rd Floor, New D.P.Road, Near Ashoka Hotel, Vishal Nagar, Pimple Nilakh, Pune- 411027, Maharashtra.
Alternatively, claim documents can also be sent to your nearest branch.

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