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 Janata Personal Accident Policy (Group) Claim Form

Basic Information :

Policy No:	Certificate No./Claim No:
Insured Name:	
Insured Person Name:	
Claimant Name:	
Relationship:	
Address:	
City:	Pin:
Contact No: Residence:	Office:
Mobile No.:	
Occupation:	DOB:

Accident Details :

Date of Accident/Hospitalisation/Loss:	
Time of Accident/Hospitalisation/Loss:	
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 No. :		

Tick Against the Section Claimed for:

1. Accidental Death	Yes/No
2.Permanent Total Disablement	Yes/No
3. Permanent Partial Disablement	Yes/No

Treatment Details

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

UIN: LIBPAGP22194V022122

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 Janata Personal Accident Policy (Group) Claim Form

Details Of Hospitalization

Name of the Hospital where admitted:		
Date of Injury First Diagnosed:		
Date of Admission:		
Date of Discharge:		
If Injury, give cause : 1. Self-Inflicted	2. Road Traffic Accident	3. Substance Abuse or Alcohol Consumption
If Medico legal : Yes/ No		
Reported to Police : Yes/ No		
MLC Report or Police FIR Attached : Yes/ No		
Details of Benefit Claimed :		

DETAILS OF ACCIDENT(Tick Against the benefit claimed for):

Basic Cover :	1. Death	2. PTD	3. PPD
Reported to Police	Yes / No		
FIR No :			
If not reported to police , give reasons :			

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

DETAILS OF PRIMARY INSUREDS BANK ACCOUNT

a)	PAN Number. :	
b)	Account Number:	
c)	Bank Name / Branch:	
d)	Payable To :	
e)	IFSC Code	

Declaration:

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact, my right to claim / reimbursement shall be forfeited. I also consent & authorize insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I also consent Insurance company to share my claim related information / documents to any third-party agency or service provider or investigation agency for the sole purpose of claim related enquiry/transaction only. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any. I agree to provide additional information to the company, if required.

Place:
Date: Sign/ Thumb Impression of the Insured/ Insured Person/claimant

Date Signature and Seal of the Doctor / Hospital

UIN: LIBPAGP22194V022122

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 General Insurance™

Liberty Janata Personal Accident Policy (Group) Claim Form

TO BE FILLED IN BY THE HOSPITAL:	
The issue of this form is not to be taken as an admission of liability	
Please include the original preauthorization request form in lieu of PART A	
Section A Hospital Details:	
Name of the Patient	
IP Registration Number	
Date of Admission	Time of admission
Date of Discharge	Time of discharge
Status at the time of Discharge:	
Discharge to Home / Discharge to another Hospital / Deceased	
Total Claimed Amount:	

SECTION B: DETAILS OF HOSPITAL:
a) Hospital ID:
b)Type of Hospital:
c) Name of the treating Doctor:
d) Qualification:
e) Registration No. with State Code:
f) Phone No:

DECLARATION BY THE HOSPITAL

We hereby declare that the information furnished in this Claim Form is true and correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppressed or concealed any material fact, our right to claim under this Policy shall be forfeited.

SEAL & SIGNATURE OF THE HOSPITAL AUTHORITY

Date
Place

UIN: LIBPAGP22194V022122

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 General Insurance™

Liberty Janata Personal Accident Policy (Group) Claim Form

Attending Physician Statement (To be filled by Treating Doctor)		
Name & Age of the Insured Person		
Address		
Nature of the accident		
Details of the injury sustained		
Does the cause of accident as stated by 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 what period?	From	To
What treatment was given, and operation performed?		
Date of treatment: Clinic/Hospital	From	To
Home	From	To
Was He/she under the impression of intoxicants or drugs at the time of accident?	YES	NO
Are you a Family doctor of patient?	YES	NO
Please provide details if you have treated the patient previous injury or illness	YES	NO
Have other doctors' been in consultation or attendance? If Yes, please give details	YES	NO
Has the accident been reported to police authorities? If Yes, please provide details	YES	NO
Case No. Police Station.		
Is this claimant totally disabled from each occupation?	YES	NO
How long will the claimant totally disable from occupation?	From	To
How long will the claimant partially disable from occupation?	From	To
Estimated date of return to work	Date: DD/MM/YYYY	
What is the prognosis?		
Doctor Name		
Qualification		
Address		
Tel No.		
Registration Number		
Signature		

UIN: LIBPAGP22194V022122

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 Janata Personal Accident Policy (Group) Claim Form

CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

Personal Accident benefit

A. Accidental Death

1. Duly filled and signed claim form.
2. FIR / MLC from police authorities.
3. Driving License of the Insured Person in case death or injury because of Road Traffic accident and the Insured Person was driving the vehicle involved.
4. Death Certificate issued by competent Authorities.
5. Death Summary from the Hospital Authorities if death is confirmed by the Hospital.
6. Post Mortem Report if conducted (Viscera report may asked in case chemical analysis preserved)
7. Inquest / Panchnama Report.
8. Letter from HR stating the attendance closure to the incident in case if employee for Group policies.
9. Indemnity Bond / Succession Certificate/ Legal Heir Certificate.
10. Latest Photograph of the beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done.
11. Photo ID proof of the beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done.
12. Address proof of the beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done.
13. NEFT mandate form filled by beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done
14. Outstanding Loan Statement

B. PTD/PPD Claim Check List:

a. Duly filled and signed claim form
b. FIR / Medico Legal Case (MLC) report from police authorities.
c. Driving License of the Insured Person in case of injury because of Road Traffic accident and the Insured Person was driving the vehicle involved.
d. Medical Certificate from the attending Medical Practitioner for the injury indicating the extent of disability.
e. Hospital / Nursing Home Medical Records.
f. Radiological / X Ray report relevant to the disability.
g. Photographs of the insured showing affected area.
h. Photo ID proof of the deceased / Insured Person in whose name the payment is to be done.
i. Address proof of the deceased / Insured Person in whose name the payment is to be done.
j. NEFT mandate form filled by deceased / Insured Person in whose name the payment is to be done.
k. Disability Certificate from Civil Surgeon in PPD & PTD Claim.

UIN: LIBPAGP22194V022122