Chola MS
GENERAL INSURANCE

PERSONAL ACCIDENT CLAIM FORM

THE ISSUANCE OF THIS FORM DOES NOT IMPLY ADMISSION OF LIABILITY.

CRM Intimation No		Claim No			
Policy No		From		To	
Sum Insured					
Policy Purchased From:	☐ Online ☐ Agent ☐ Broker ☐ Bancassurance				
Having any policy from another company:	☐ Yes ☐ No				
Company Name					
Policy No		From		To	
Sum Insured					

WHICH BENEFIT TO AVAIL : PLEASE TICK

Accidental Death	☐	Permanent Total Disability	☐
Permanent Partial Disability	☐	Accidental Medical Reimbursement	☐
Education Benefit	☐	Accidental Weekly Benefit	☐
Any other benefit			

COMMUNICATION ADDRESS FOR CLAIMS REQUIREMENT*

Claimant Name					
Date of Birth		Gender:	Male ☐ Female ☐ Transgender ☐		
Marital Status		Single ☐ Married ☐			
Relation with the Injured/Deceased					
Communication address		☐ Permanent ☐ Temporary			
Door No		Street Name			
Taluk		District/City		State	
Pincode		Contact No:		Email Id:	

Note : Address/Phone number/Email ID is mandatory to know the live claim status **

INFORMATION ABOUT INJURED/DECEASED PERSON

Insured Name					
Date of Birth		Gender:	Male ☐ Female ☐ Transgender ☐		
Marital Status		Single ☐ Married ☐			
Occupation:	☐ Private ☐ Service	☐ Self-Employee ☐ Salaried			
Nature of work					
Employee Id No		Company Name			
Annual Income		Designation:			

INFORMATION ABOUT ACCIDENT

Natural ☐	Unnatural ☐	Homicide ☐	Suicide ☐
Date of Accident		Time	
Accident Location with Address			
Detailed Description Of The Accident:			
Any Eye Witness	☐ Yes ☐ No	☐ Relation	☐ Unknown
Witness name with address:			
Contact No			

Chola MS
GENERAL INSURANCE

HOSPITAL DETAILS

Any treatment taken after an accident				☐ Yes	☐ No
Hospital Name with Address					
If multiple hospital, please mention the details					
MLC No:		Date of Admission		Date of Discharge	
Date of Death		Place of Death with Address			
Cause of Death					

POLICE INTIMATION DETAILS

Whether Accident Intimated To Police						☐ Yes	☐ No
Whether Police Verified the Accident Spot						☐ Yes	☐ No
Police Station Name with Address							
MLC No:		FIR no.		Date of FIR		Time	
Complaint Name with Relation Details							
FIR against For whom:				IPC Section			

POST MORTEM DETAILS

Whether Post Mortem Done				☐ Yes	☐ No
Hospital Name with Address					
Date of Post Mortem				Time	
Post Mortem Done By Forensic Medicine Officer:				☐ Yes	☐ No
If Yes, Mention The Doctor Reg No:					

DETAILS OF CLAIMANT/NOMINEE

Nominee Name :					
Relation With Insured		Date Of Birth		Age	
Gender	☐ Male ☐ Female	Address:	☐ Permanent ☐ Temporary		
Door No		Street Name			
Taluk		District/City		State	
Pincode		Contact No :		Email Id	
If Nominee Is Minor, Kindly Provide The Legal Guardian Details					
Name Of Guardian		Age		Gender	☐ Male ☐ Female
Relationship With Insured				Address	☐ Permanent ☐ Temporary
Door No		Street Name			
Taluk		District/City			
State		Pincode			
Nominee Signature/Thumb Impression		Date			

Declaration :

I/We hereby to the best of my/our knowledge and belief, warrant the truth of the above details in every respect. I/ We agree that if we have made already or if I/We make in any of my/our further statements in respect of the said incident any false or fraudulent declarations or suppress or conceal any material fact, the Policy shall be void and all rights of compensation in respect of the present or future accident shall be forfeited.

Chola MS
GENERAL INSURANCE

MEDICAL CERTIFICATE (TO BE FILLED BY REGISTERED DOCTOR)

Name Of Insured		**Age**		**Gender**	**Male** ☐ **Female** ☐
Current Address					
Hospital Name with address					
Cause Of Accident :					
Injuries were due to accident					☐ **Yes** ☐ **No**
Insured Have Any Medical History					☐ **Yes** ☐ **No**
If Yes,					
At the time of accident insured was under influence of drugs / alcohol / intoxicants?					☐ **Yes** ☐ **No**
If Yes,					

DETAILS OF DISABILITY

Permanent Total Disablement			
Loss Of		**Percentage Of Disability**	
Permanent Partial Disablement			
Loss Of		**Percentage Of Disability**	
Temporary Total Disablement	☐ **Yes** ☐ **No**		
If Yes,			

To Whom It May Concern

I, Dr. ..... After careful personal examination of the case hereby certify that shri /smt./ms. ..... (name & designation of applicant) of the office of the .....whose signature is given above is suffering from ..... And, therefore, I consider, that a period of absence from duty from .....to ..... With effect from ..... is absolutely necessary for the restoration of his/her health.

Date of fitness to resume duty:			
I certify that I have examined the above named insured, the above statements are correct.			
Hospital Name:		**Name Of Examined Doctor**	
Qualification		**Reg No**	
Date : **Place :**		**Signature with Seal**	

PAYABLE TO NOMINEE

Bank Name		**Account Holder Name**	
Account No		**IFSC Code**	
MICR No		**Pan No.**	
Bank Branch			

Chola MS
GENERAL INSURANCE

CLAIM DOCUMENTS CHECK LIST

For Death Claim		For Permanent Total Disablement, Permanent Partial Disablement, Accident Weekly Benefit, Broken Bones	
1	Filled Claim form	1	Filled Claim form
2	First Aid treatment records	2	First Aid treatment records
3	Medicolegal Certificate	3	Indoor case papers (if hospitalized)
4	Indoor case papers (if hospitalized)	4	Discharge Summary
5	Copy of driving License	5	Consultation papers
6	FIR Copy	6	Medicolegal Certificate
7	Post Mortem Report	7	Fitness Certificate
8	Death Certificate	8	All original Medical bills, Final bill & paid receipts, Final bill breakup, Medicine Breakup
9	Payee Neft documents	9	OPD treatment/follow up records from date of an accident to till fitness
10	Insured KYC documents	10	Settlement letter from other insurance company (if claimed any Mediclaim)
11	Nominee ID proofs	11	Full photograph of the insured (After the accident) & Snap shot of injured spot
12	Final report from the police	12	Employee ID card/Student ID card
13	Viscera report	13	Payee Neft details (Insured or claimant)
14	Spot panchanama	14	KYC documents
15	Inquest panchanama	15	HR Leave certificate along with attendance register during leave periods
		16	Driving License (if RTA)
		17	FIR Copy/GD/Panchanama
		18	X-Ray films with reports/MRI Scan reports
		19	Last three month payslip (Prior to an accident)
		20	Disability certificate from civil surgeon (for disability claim)
		21	Written statement about the accident (When, where & How)

Loan Protection cover		For Motor PA Death Claim	
In addition to documents required in case of Death or Permanent Total disability.		1	Filled Claim form
1	Outstanding Loan Statement for a period of 6 months which includes date of accident.	2	First Aid treatment records
2	Monthly EMI statement from lender/s	3	Medicolegal Certificate
Modification of Residential Accommodation and Vehicle		4	Indoor case papers (if hospitalized)
In addition to documents required in case of Permanent Total disability		5	Copy of driving License
1	Full photograph of resident/vehicle	6	FIR Copy
2	Photos of before and after modified location	7	Post Mortem Report
3	Original bills for modification	8	Death Certificate
4	RC copy & vehicle insurance copy	9	Payee Neft documents
Educational Benefit/Girl Child Marriage Grant		10	Insured KYC documents
In addition to documents required in case of Death or Permanent Total disability.		11	Nominee ID proofs
1	Birth Certificate/age proof of the child / children	12	Final report from the police
2	Bonafide student certificate from the school where the child is studying for educational benefit	13	Viscera report
3	Affidavit for Marriage status – for Girl Child Marriage Grant	14	Spot panchanama
		15	Inquest panchanama
		16	Indemnity Bond (100 RS stamp paper)
		17	Affidavit (100 RS stamp paper)
		18	Legal heir certificate
		19	Family Card
		20	RC Copy
		21	Policy copy

Address to dispatch the claim documents: **CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED**
HAT Claim Office: New No. 319, Old No. 154, Shaw Wallace Building, 2nd Floor, Thambu Chetty Street, Chennai - 600001. T: +91 (0) 44 4044 5400
Chola MS customer support operates 24/7 basis and the contact details are as followed for any queries / grievance: Toll Free Phone No: **1800 208 9100** | E-Mail: **customercare@cholams.murugappa.com**