

Hospital Treatment Certificate/ APS - Accidental Disability/ Dismemberment Claim

Accidental Disability / Dismemberment Claim under Policy No. _____ on the life of
_____ (Full Name of the Life Assured)

Following information should be furnished as per Hospital Records

1) a) Name : _____

b) Age: _____ Years: _____ Months: _____ c) Occupation: _____

d) Address: _____

e) Identification mark (if any): _____

2) a) Date of Accident: ____/____/____

b) Time of Accident: ____/____ am/pm c) Place of Accident : _____

3) a) Date of Admission: ____/____/____

b) Time of Admission ____/____ am/pm c) Admission Number: _____

4) a) Nature of Accident : RTA Worksite Others

a. Description of the Accident: _____ (e.g. Road Traffic Accident, Drowning etc.)

b. Nature of Injury/ies suffered by the Insured (whether self-inflicted or otherwise) : _____

e) Name and contact number of the doctor who recorded history: _____

5) If the injured was referred to you, please state the Name & Address of the Hospital/ Doctor concerned: _____

6) Did the accident occur under the influence of alcohol/drugs/narcotics or any non-prescribed medicine: _____

7) Please provide details and dates of the investigations conducted during the stay in the hospital. (if so please attach copies)

Date : ____/____/____ Investigation Details: _____

Date : ____/____/____ _____

8) Please give details of the treatment/rendered to/surgical procedure undergone by the insured.

Please furnish details in separate sheets if required.

9) What was the diagnosis arrived at in the Hospital?

10) Please Describe the exact type of Dismemberment/Disability suffered as a consequence of the accident as mentioned above

11) Nature of impairment Temporary Permanent

12) Are you aware of any illness/ disease, disorder (including any psychic or mental disorder) which the insured was suffering from prior to this accident? If yes, give brief particulars of it _____

13) Date of discharge from Hospital ___/___/___

14) Condition at the time of discharge _____

15) Follow up treatment advised _____

16) What is the prognosis? _____

17) Was the accident reported to the police? Yes No

If so, please furnish the name and address of the police station and the date and time of the report:

18) Was the Disability/Dismemberment of the Insured caused solely by injuries suffered by him in the accident?

19) Any other information, which you consider, would be vital in the claim review process under this policy?

Certified that the above information is true and correct as per the records of the Hospital

Date	
Signature	
Name of Doctor	
Code no	
Qualification & Designation	
Hospital Name	
Hospital Address	
Contact No	
Hospital Stamp	