Liberty General Insurance

OPTIONAL TRAVEL INSURANCE FOR E-TICKET PASSENGERS- INDIAN RAILWAY CATERING AND TOURISM CORPORATION, LIBERTY GENERAL INSURANCE LTD.

Basic Information :	
Policy No:	Claim No:
Insured Name:	
Insured Person Name:	
Claimant Name:	
Relationship:	DOB:
Address:	
City:	Pin:
Contact No: Residence:	Office:
Mobile 1:	Mobile 2:
Occupation:	PNR:

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 1:	Mobile 2:

Tick Against the Section Claimed for:	
Basic Covers:	1. Accidental Death
	2.Permanent Total Disablement (PTD)
	3 Permanent Partial Disablement (PPD)
	4 Hospitalization Expenses for Injury
	5 Transportation of Mortal Remains

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

Confinement		
Inpatient treatment	From dd / mm / yyyy	To dd / mm / yyyy
Outpatient treatment	From dd / mm / yyyy	To dd / mm / yyyy
Total Confinement	From dd / mm / yyyy	To dd / mm / yyyy
(This should be the actual days when fully confined to bed on Medical Advice)		

Details of medical expenses:

Date	Receipt No.	Particulars	Amount
dd / mm / yyyy			
dd / mm / yyyy			
dd / mm / yyyy			
dd / mm / yyyy			
dd / mm / yyyy			
dd / mm / yyyy			
dd / mm / yyyy			
dd / mm / yyyy			
dd / mm / yyyy			
dd / mm / yyyy			
dd / mm / yyyy			
dd / mm / yyyy			

Please attach separate sheet for additional bills/receipt details

DETAILS OF HOSPITALIZATION

A.	Name of The Hospital Where Admitted:			
B.	Room Category Occupied:	Day Care Single	Occupancy Twin Sharing	3 Or More
C.	Hospitalization Due To: Illness Injury			
D.	Date of Injury			
E.	Date of Admission:			
F.	Date of Discharge:			
G.	If Injury, Give Cause:	Self-Inflicted	Road Traffic Accident Substance	Substance Abuse or Alcohol Consumption
H.	If Medico Legal:	Yes/ No		
I.	Reported to Police:	Yes/ No		
J.	MLC Report or Police Fir Attached:	Yes/ No		

DETAILS OF CLAIM:

Detail of benefit claimed	
SECTION B: DETAILS OF THE PATIENT ADMITTED	
A) Have you made any Claims in Past?	Yes/ No
B) If YES, please give details including nature of Accident/Hospitalization/Loss, 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

Transportation of Mortal Remains
Expense incurred towards cost of transportation of the mortal remains

DETAILS OF PRIMARY INSUREDS BANK ACCOUNT	
a) PAN Number. :	
b) Account Number:	
c) Bank Name / Branch:	
d) Payable To (Account Holder's Name):	
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

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 Home	From From	To 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
Did you have other doctors' consultation or attendance? If Yes, please give details		YES	NO
Has the accident is 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

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
Type of Admission: Emergency Planned Day Care Maternity	
Status at the time of Discharge:	
Discharge to Home Discharge to another Hospital Deceased	
Total Claimed Amount:	
SECTION C: DETAILS OF AILMENT DIAGNOSED:	
Ailment Diagnosed (Primary)	
Codes Description	
Additional Diagnosis	
Codes Description	
a) Name of Hospital:	
b) Hospital ID:	
c)Type of Hospital: Network Non-Network (If Non-Network Fill Sec E)	
d) Name of the treating Doctor:	
e) Qualification:	
f) Registration No. with State Code:	
g) Phone No:	