Accidental Death Annex –D Form "E"

Claimant's Statement

INSURED INFORMATION

Insured"s Name_____ Date of Birth ___/____/____

Marital Status _____

Insured"s Address

_____

Name and address of Last Employer

_____

_____

Policy Number _____ Insured"s Occupation (at time of death) _____

Did the Insured have any other accident or life insurance? _____ If yes, please list all companies, policy numbers and insurance amounts_____

_____

CLAIM INFORMATION

Date of accident _____/_____/_____ Time and place accident occurred_____

Please describe in detail the circumstances of accident (attach separate sheet if needed):

_____

_____

Was the accident related to the Insured"s occupation? _____ If so, how? _____

Please describe the cause of the Insured"s death:

_____

Please list the names and addresses of all treating physicians and Hospitals :_____

_____

Did police or other authorities investigate the accident? _____ If yes,

Please provide name, address and telephone number of all investigating officers and agencies:

_____

Was an autopsy performed?_____ If yes, please provide name and address of Medical Examiner_____

_____

Was a coroner"s inquest held? _____If yes, what was the determination?_____

CLAIMANT INFORMATION

Claimant"s Name_____ Age_____

Relationship to Insured_____

Claimant"s Address_____

_____

Phone No.(H)_____Phone No.(W)_____

In what capacity are you making this claim? _____ Beneficiary _____ Executor* _____ Administrator* _____ Guardian* _____Trustee* _____Assignee*

*Please provide a certified copy of all documents supporting your authority (e.g., Succession Certificate, Notarised Affidavit, Notarised will, etc.)

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by HDFC ERGO General Insurance, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Place: _____

DATE ____/____/____ SIGNED (Claimant or authorized person)