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MDINDIA HEALTHCARE SERVICES (TPA) PVT. LTD.
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 Pune – 411014. UAN Voice No. 1860-233-4446. UAN Fax No. 1860-233-4447
 E-mail ID: pune@mdindia.com - Website: www.mdindiaonline.com



CLAIM FORM

National Insurance Company The New India Assurance Company
 Oriental Insurance Company The United India Insurance Company

- Current Policy no.
- MDIndia ID No.: MD15-
- Corporate Name : Employee Code :
- Name & Address of the Policy Holder:
- Name of the Patient:
- Present Contact Address:
- Contact No. (Resi. / Office): Mobile No.:
- Have you preferred any claim for the same **Insured under** the Mediclaim scheme earlier, if so give details viz

Sr. No.	Particulars	Claim 1	Claim 2	Claim 3	Claim 4
(a)	Policy Number				
(b)	Date of Admission				
(c)	Date of Discharge				
(d)	Diagnosis				
(e)	Whether settled / repudiated				
(f)	Claim Amount (if settled) : Rs.				

- Since when the person covered under the policy without break _____ yrs.
Photocopies of previous year's policies MUST be enclosed:
- If the claim is of Domiciliary Hospitalization please indicate
 - Date of Commencement of the treatment _____
 - Date of Completion of treatment _____
 - Name & Address of attending Medical Practitioner _____
 - Contact No. _____ Registration No. _____ Qualification: _____



Retail Health Policy **MOTOR CLAIM FORM** **Home & Family Protector**
 a. Individual Medishield **IFFCO TOKIO GENERAL INSURANCE COMPANY LTD.** **Home Suvidha Policy**
 b. Swasthya Kavach policy Regd. Office: Iffco Sadan Saket **Trade Protector Policy**
 To intimate a claim please call on Toll Free:-1800-1035-499
Office & Professional Establishment Protector **Trade Suvidha Policy**

1. Important Instructions

- The insurance of this form is not to be taken as an admission of liability.
- To be signed by the Insured(Registered Owner) of the vehicle, or where Insured(Registered Owner) is a Partnership or Corporate Body, by an authorized signatory of such Partnership or Corporate Body along with the office seal of the concerned organization.
- Please do not leave any column unanswered.
- All facts and Statements must be factual not influenced or biased in any form.
- The damaged vehicle must be parked at safe place to avoid any subsequent damage/loss. The Company will not be responsible for the same.
- Please read carefully the attached list of documents required for faster processing of your claim.
- All documents provided by the Insured must be Self Attested.

2. Details of Policy Holder

Policy No/Cover Note : _____ Claim No : _____
 Period of Insurance : From _____ To _____
 Name of the Insured : _____
 Phone Number (Home/Office) : _____ Mobile Number: _____
 Name of Registered Owner : _____
 Current Address : _____ Email: _____
 Gender : Male / Female Date of Birth : (dd/mm/yyyy): _____

3. Details of Incident (Accident / Theft)

Date(dd/mm/yy) : _____ Time (a.m./p.m.) : _____ Speed (km/hr) _____
 Exact Place Where incident occurred : _____
 Place to which the vehicle was heading for before incident : _____
 Purpose for which vehicle was being used/parked at the time of incident: _____
 Nature & Weight of goods carried at the time of incident (Comm. Veh): _____
 No of people travelling at time of incident : _____ Is it reported to the Police ? YES / NO
 Name & Address of the Police Station : _____
 Gen. Diary/Crime No/FIR No and Date: _____
 Name and Address of the place where Insured vehicle is parked: _____
 Estimated Loss Amount (Rs.) : _____

PLEASE READ BOTH SIDES OF THIS FORM BEFORE COMPLETING IT (PLEASE PRINT)

Your Name, Mailing Address, Business Name, Home Phone, Business Phone, Account Number, Location of Incident, Date and time of loss

Loss related to: (circle) Gas / Electric / Vehicle Weather conditions: (circle) Rain / Snow / Lightning / Wind / Fair / Other

Briefly describe the events causing the damage/loss or personal injury. If known, include the name of Liberty Utilities employees or contractors involved.

List the items damaged: YOU MUST INCLUDE MAKE, MODEL, NUMBER and DATE OF ORIGINAL PURCHASE and PURCHASE PRICE. Enclose a written repair bill or estimate for each damaged item.

INSURANCE COMPANY NAME: POLICY NUMBER

Have you made a claim for this loss with your insurance carrier?

Claimant's Signature Date



Engineers Report Form

IMPORTANT: Liberty Insurance Cover can be confirmed in relation to the vehicle, it is necessary to have this Engineers Report Form completed by one of the following: - Motor Dealer - Member of the Institute of Automotive Engineers - RAC Approved Garage - ANZI Post Centre

Please submit a copy of the front and back of your driving license

Personal Details

Name of the Insured Person, Quote / Policy Number, Address

Vehicle Details

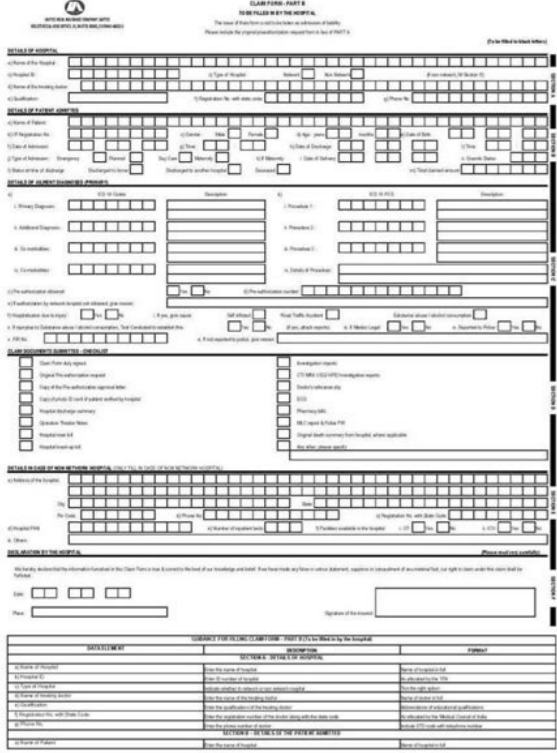
Cubic Capacity, Mileage, Year, No of Seats, Estimated Value, Make and Model of Vehicle, Registration of Vehicle

Please tick the appropriate response

1. Electrical, 2. Steering, 3. Brakes, 4. Tyres/Tyres, 5. Modifications

If Yes, please give details below

Please return to: Liberty Insurance, Dublin Road, Coram, Co. Cork, Rep. Ireland



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health insurance company in India. Care Health Insurance Company Limited guarantees access to inventive and financially effective health insurance products.

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