Liberty General Insurance Limited
Unit 1501&1502, 15th Floor, Tower 2, One International Center,
Senapati Bapat Marg, Prabhadevi, Mumbai – 400013
Phone: +91 22 6700 1313 Email: care@libertyinsurance.in
IRDA of India registration number: 150 ● CIN: U66000MH2010PLC209656

Liberty General Insurance

LIBERTY COMPLETE PROTECT GROUP POLICY

CLAIM FORM

(To be filled in Block Letters)

BASIC INFORMATION

Policy Number : Certificate No/Claim No:

Insured Name :

Insured Person Name :

Claimant Name :

Relationship :

Address :

City : Pin Code :

Contact No : Residence : Office : Mobile :

Occupation : DOB: d d m m y y y y

ACCIDENT DETAILS

Date of Accident / hospitalization / Loss d d m m y y y y Time of Accident / hospitalization / Loss h h m m s s

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 :

City : Pin Code :

Contact No : Residence : Office : Mobile :

TICK AGAINST THE SECTION CLAIMED FOR

Section I – Daily Hospital Cash Benefit	
Section II – Personal Accident Benefit	
Section III – Critical Illness Benefit	
Section IV – Vector Borne Diseases Benefit	
Section V – EMI Protector Benefit	
Section VI – Loan Protector Benefit	

TREATMENT DETAILS

Casualty Doctor:

Name :

Address :

City : Pin Code :

Tel Nos:

UIN: LIBHLGP23119V022223

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CLAIM FORM

Family Doctor :

Name :

Address :

City : Pin Code :

Tel Nos:

Hospital Details :

Name :

Address :

City : Pin Code :

Tel Nos:

DETAILS HOSPITALIZATION

Name of the Hospital where admitted: _____

Room Category Occupied: ☐ 1. Day Care ☐ 2. Single Occupancy ☐ 3. Twin Sharing ☐ 4. Multi bed (3 or more)

Hospitalization due to : ☐ Illness ☐ Injury

Date of Injury / Disease First Diagnosed: _____

Date of Admission: _____

Date of Discharge: _____

If Injury, give cause : ☐ 1. Self-Inflicted ☐ 2. Road Traffic Accident ☐ 3. Substance Abuse or Alcohol Consumption

If Medico legal : ☐ Yes ☐ No

Reported to Police : ☐ Yes ☐ No

MLC Report or Police FIR Attached : ☐ Yes ☐ No

Details of Benefit Claimed : _____

Name of Critical Illness : _____

DETAILS OF ACCIDENT (TICK AGAINST THE BENEFIT CLAIMED FOR)

Basic Cover : ☐ 1. Death ☐ 2. PTD ☐ 3. PPD ☐ 4. TTD

Extension Covers:
Child Education Support
Transportation of Mortal Remains
Accidental Medical Expenses
Performance of Funeral Ceremony
Modification of Vehicle / Residence
Ambulance Hiring Charges

Reported to Police ☐ Yes ☐ No

FIR No : _____

If not reported to police, give reasons : _____

CONFINEMENT

Inpatient treatment	From	d	d	m	m	y	y	y	y	To	d	d	m	m	y	y	y	y
Outpatient treatment	From	d	d	m	m	y	y	y	y	To	d	d	m	m	y	y	y	y
Total Confinement	From	d	d	m	m	y	y	y	y	To	d	d	m	m	y	y	y	y

(This should be the actual days when fully confined to bed on Medical Advice)

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CLAIM FORM

DETAILS OF MEDICAL EXPENSES

Date	Receipt No	Particulars	Amount

Please attach separate sheet for additional bills / receipt details

POLICY AND CLAIMS HISTORY

A) Have you made any Claims in Past? ☐ Yes ☐ No

B) If YES, Please give details including nature of Accident, 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

DETAILS OF PRIMARY INSUREDS / NOMINEES BANK ACCOUNT

a) PAN No. :

b) Account Number :

c) Bank Name / Branch :

d) Payable To :

e) IFSC Code :

DECLARATION

I/We agree to provide additional information to the company, if required. I/We the above mentioned, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and if I/We have made, or in any further declaration the company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, the policy shall be void and all rights to recover there under in respect of past or future accident shall be forfeited. I hereby consent to Liberty General Insurance Ltd. approaching my doctor for all information that it deems to be necessary.

I/We hereby give voluntary consent to Liberty General Insurance Limited/Company to process/share my/our personal information and data provided in this form with its group companies or any other person/ Service Provider of Company in connection with the Insurance Policy/ claims made there under or otherwise, including for providing other products of the Company that may be of interest to me/us, to be used in accordance with their respective privacy policies.

Sign/ Thumb Impression of the Insured/ Insured Person

Place : _____

Date : d d m m y y y y

_____

Signature and Seal of the Doctor

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 reauthorization request form in lieu of PART A Section A Hospital Details:

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 : ☐ 1. Emergency ☐ 2. Planned ☐ 3. Day Care ☐ 4. Maternity

Status at the time of Discharge : ☐ Discharge to Home ☐ Discharge to another Hospital ☐ Deceased

Total Claimed Amount :

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CLAIM FORM

Section B – Details of Ailment Diagnosed

Ailment Diagnosed (Primary) : _____

Codes Description : _____

Additional Diagnosis : _____

Section B – Details of Hospital

Hospital ID : _____

Type of Hospital : _____

Name of the treating Doctor : _____

Qualification : _____ Registration No. with State Code : _____

Phone No : _____

DECLARATION BY THE HOSPITAL

We hereby declare that the information furnished in this Claim Form is true and correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppressed or concealed any material fact, our right to claim under this Policy shall be forfeited.

Place : _____

Date : d d m m y y y y

_____

SEAL & SIGNATURE OF THE HOSPITAL AUTHORITY

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CLAIM FORM

ATTENDING PHYSICIAN STATEMENT

To be filled by the Treating Doctor

Name & Age of the Insured Person		
Address		
Nature of the Accident		
Details of the Injuries sustained		
Does the Cause of Accident as stated by the 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 for what period?	From	To
What treatment was given and operations performed?		
Give all dates of treatment:	Clinic Hospital: From Home: From	To To
Was he / she under the influence of intoxicants or drugs at the time of accident?	Yes ☐	No ☐
Are you his family doctor?	Yes ☐	No ☐
Please give the details, If you have treated him for an previous illness or injury?		
Have other Doctors been in Attendance or Consultation? If Yes, Please give the details	Yes ☐	No ☐
Has this accident been reported to the Police Authorities? If Yes, then please provide	Yes ☐ Case No:	No ☐ Police Station
Is this claimant Totally Disabled from each and every occupation?	Yes ☐	No ☐
How long was or will the claimant be totally disabled from current occupation?	From	To
How long was or will the claimant be partially disabled from current occupation?	From	To
Estimated date of return to Work	Date	
What is the Prognosis?		
Doctor's Name		
Qualification		
Address		
Tel No		
Registration No		
Signature		

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CLAIM FORM

CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

Section I: Daily Hospital Cash:

1. Duly Filled and signed claim form;
2. Copy of discharge summary/ Final bill/ investigation reports.
3. Photo ID proof of the insured member whose name the payment is to be done.
4. Address proof of the insured member whose name the payment is to be done.
5. NEFT mandate form filled by deceased / Insured Person in whose name the payment is to be done
6. Indoor case papers from hospital.

Section II: Personal Accident benefit

A. Accidental Death

1. Duly filled and signed claim form.
2. FIR / MLC from police authorities.
3. Driving License of the Insured Person in case death or injury because of Road Traffic accident and the Insured Person was driving the vehicle involved.
4. Death Certificate issued by competent Authorities.
5. Death Summary from the Hospital Authorities if death is confirmed by the Hospital.
6. Post Mortem Report if conducted (Viscera report may asked in case chemical analysis preserved)
7. Inquest / Panchnama Report.
8. Letter from HR stating the attendance closure to the incident in case if employee for Group policies.
9. Indemnity Bond / Succession Certificate/ Legal Heir Certificate.
10. Latest Photograph of the beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done.
11. Photo ID proof of the beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done.
12. Address proof of the beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done.
13. NEFT mandate form filled by beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done
14. Outstanding Loan Statement

B. PTD/PPD Claim Check List:

a. Duly filled and signed claim form
b. FIR / Medico Legal Case (MLC) report from police authorities.
c. Driving License of the Insured Person in case of injury because of Road Traffic accident and the Insured Person was driving the vehicle involved.
d. Medical Certificate from the attending Medical Practitioner for the injury indicating the extent of disability.
e. Hospital / Nursing Home Medical Records.
f. Radiological / X Ray report relevant to the disability.
g. Photographs of the insured showing affected area.
h. Photo ID proof of the deceased / Insured Person in whose name the payment is to be done.
i. Address proof of the deceased / Insured Person in whose name the payment is to be done.
j. NEFT mandate form filled by deceased / Insured Person in whose name the payment is to be done.
k. Disability Certificate from Civil Surgeon in PPD & PTD Claim.

C. TTD Claim Check List

1. Duly filled and signed claim form
2. FIR / MLC from police authorities.
3. Driving License of the Insured Person in case of injury because of Road Traffic accident and the Insured Person was driving the vehicle involved.
4. Medical fitness certificate from the Treating consultant indicating duration of rest medically advised
5. Hospital / Nursing Home Medical Records.
6. Radiological / X Ray report relevant to the disability.
7. Leave certificate from HR (for salaried people) if employee for Group policies.
8. Salary certificate / income proof if employee for Group policies.
9. Photo ID proof of the deceased / Insured Person in whose name the payment is to be done.
10. Address proof of the deceased / Insured Person in whose name the payment is to be done.
11. NEFT mandate form filled by deceased / Insured Person in whose name the payment is to be done.

Optional Cover Under Section II Personal Accident Benefit

A. Child Education Support:

1. Proof of number of dependent child /children viz. Ration card
2. Age proof of the dependent child /children
3. Proof of education and payment of fee

B. Accidental Medical Expenses

1. Copy of document of hospitalization/medical treatment
2. Certificate from treating doctor about the diagnosis and line of treatment given during hospitalization/medical treatment
3. Bills and receipts towards medical expenses.
4. Copy of the test reports
5. Hospital / Nursing Home Medical Records, when required for verification of claims.

C. Transportation of Mortal Remains:

1. Bills and receipt towards cost of transportation of the mortal remains to the place of residence/hospital and/or cremation/burial ground.
2. NEFT mandate form filled by deceased / Insured Person in whose name the payment is to be done

D. Performance of Funeral Ceremony

1. Bills and receipt towards expenses relevant to funeral ceremony
2. NEFT mandate form filled by deceased / Insured Person in whose name the payment is to be done

E. Ambulance Hiring Charges

1. Bills and receipt towards cost of ambulance services
2. NEFT mandate form filled by deceased / Insured Person in whose name the payment is to be done

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CLAIM FORM

F. Modification of Vehicle/Residence

1. Permanent Total Disability / Permanent Partial Disability related documents
2. Bills and receipts towards vehicle or residence modifications

Section III: Critical Illness Benefit:

1. Dully filled & signed claim form
2. Investigation reports, Histological report or Scan/ X Ray Plates, etc. as applicable confirming diagnosis of the indicated Critical Illness
3. All Documents prior and after, related to the diagnosis of indicated critical illness
4. Medical certificate from the certified Physician confirming the diagnosis of Indicated critical illness
5. NEFT mandate form filled by deceased / Insured Person in whose name the payment is to be done

Section IV: Vector Borne Diseases Benefit

A. In-patient Hospitalization Benefit

1. Duly Filled and signed claim form;
2. Copy of discharge summary/ Final bill/ investigation reports.
3. Photo ID proof of the insured member whose name the payment is to be done.
4. Address proof of the insured member whose name the payment is to be done.
5. NEFT mandate form filled by deceased / Insured Person in whose name the payment is to be done
6. Indoor case papers from hospital.

B. Double Vector Borne Diseases Benefit:

1. Duly filled and signed claim form.
2. Copy of discharge summary/ Final bill/ investigation reports
3. Indoor case papers from hospital
4. Latest Photograph of the beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done.
5. Photo ID proof of the beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done.
6. Address proof of the beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done.
7. NEFT mandate form filled by beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done

Section V & VI: EMI Protector and Loan Protector Benefit:

1. Duly completed claim form;
2. Certificate if applicable from the Bank stating the amortization schedule, the EMI Amounts, Principal Outstanding, etc.
3. Certificate from the employer of the Insured Person confirming the termination, dismissal temporary suspension or retrenchment from employment of the Insured person furnishing the date of termination, dismissal, temporary suspension or retrenchment from employment of the Insured Person with the reasons for the same. In case of temporary suspension the period of suspension should also be mentioned in such certificate.
4. Any other document as may be required by the Company.
5. Photo Id & Address Proof of insured member
6. NEFT mandate form filled by beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done

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