EDELWEISS CANCELLATION INSURANCE POLICY CLAIM FORM

Edelweiss | GENERAL INSURANCE

Toll Free 1800 12000

Issue of this claim form is not to be taken as an admission of liability

If any detail or information is not readily available please do not delay the dispatch of this form and other particulars may be sent later

Policy Number:

Claim Number:

Period of Insurance: From D D M M Y Y Y Y **To** D D M M Y Y Y Y

Details of the Insured/ Claimant

Name of the Claimant: _____ Relation with the insured: _____

Name of the Insured: _____

Address: _____

City: _____ State: _____ Pin No:

Contact Number: Email Id: _____

Booking Details

1. Booking/Ticket Reference no.: _____ 2. Mode of Purchase: _____
3. Cost of Ticket: _____ 4. Date & Time of show/event: D D M M Y Y Y Y H H M M
5. Venue of Show/Event: _____ 6. Date & Time of Cancellation: D D M M Y Y Y Y H H M M
7. Reason of Cancellation: _____

ACCIDENT DETAILS

1. Date & time of Accident/occurrence: D D M M Y Y Y Y H H M M 2. Place of Accident/Occurrence: _____
3. Description of the Accident/Occurrence: _____
4. Witness name, address and contact number: _____
5. Was the injured person under the influence of alcohol/drugs at the time of accident: Yes ☐ No ☐
6. Driving license details, in case of self-accident: _____
7. Details of Baggage/Personal Belongings lost with approximate valuation: _____

Details of Injury/Death:

1. Details of injuries sustained with name of the parts: _____
2. If disabled, specify the nature of disability: _____
3. Specify the disability percentage in case of Permanent Partial Disablement: _____
4. In case of death, Cause of death: _____
5. Nominee details (for death cases only) Name, relation with the insured and address: _____

Treatment Details

Casualty Doctor Name, address and contact number: _____

Family Doctor Name, address and contact number: _____

Hospital Details Name, address and contact numbers: _____

Confinement Details

Full Confinement period (Actual days when fully confined to bed on Medical Advice)	From: D D M M Y Y Y Y To D D M M Y Y Y Y Total days:
Partial Confinement Period	From: D D M M Y Y Y Y To D D M M Y Y Y Y Total days:

Medical Expenses – Subject to Coverage under the Policy.

Date	Receipt Number	Particulars	Amount (in ₹)

Please attach separate sheet in the above format for additional bills

Claims History

Have you made any claims in the past?	Yes ☐ No ☐
If Yes, Please give the details of cause of accident/occurrence, nature of injury, policy details and claim amount.	

Other Insurance

Are you insured under any other policy	Yes ☐ No ☐
If Yes, Please give full particulars of Name of the insurance company, Policy number, period of insurance and claim details.	

Claim under other heading (subject to policy coverage and limits)

Claim under which Coverage	Claimed Amount (in ₹)

List of Documents required for Claim Settlement

1. Claim Form
2. Police FIR / Panchnama
3. Medical Certificate
4. Investigation/Lab Test Report
5. Discharge Certificate
6. Leave Certificate
7. Disability Certificate
8. Death Certificate – for Death cases only.
9. Post Mortem Report – for Death cases only
10. Ticket - Original

Bank details for NEFT payment (Please attach a cancelled cheque)

Bank Name: _____ Branch name: _____

IFSC Code: | | | | | | | | | | | Account Number: | | | | | | | | | | | | | | | | |

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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 future 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.

Date : D D M M Y Y Y Y

Place: _____

Signature of Insured:

(Stamp, where Insured is a juristic person)

Attending Physician's Statement

1	Name of the Insured	
2	Age of the insured	
3	Address	
4	Type of accident	
5	Nature of injuries sustained	
6	Does the Cause of accident as stated by the Claimant tally with the Injuries noticed by you	Yes ☐ No ☐
7	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 ☐
8	Was the Claimant hospitalised, if yes period	From To
9	Was the treatment /Operations carried by you	
10	Give details of the treatment	Hospital: From To Home: From To
11	Was he/she was under the influence of intoxicants or drugs at the time of accident	Yes ☐ No ☐ If Yes, please provide the details
12	Are you his/her family doctor If yes, have you treated him/her for any previous illness or injury , please provide the details	Yes ☐ No ☐
13	Is there any Doctors also associated in the treatment, please provide the details	
14	Has the accident been reported to the Police Authorities, if yes please provide the details	
15	Is the claimant Totally Disable from each and every occupation	
16	How long the claimant will be totally disabled from current occupation	From To
	How long the claimant will be partially Disabled from the current location	From To
	Estimated date of return to work	
17	What is the Prognosis	

Name of the Doctor: _____

Registration Number: _____

Address: _____

Contact number: _____

Signature of the Doctor

Date