Accident Medical Claim Document

1. Claimant Information

Full Name

Date of Birth

Policy Number

Address

Contact Number

Email

2. Accident Details

Date of Accident

Time HH:MM

Location

Description of Accident

3. Injury & Treatment Information

Description of Injury

Hospital/Clinic Name

Attending Doctor

Date of First Treatment

Treatment Details

4. Claim Details

Amount Claimed

Preferred Payment Method Bank Transfer / Cheque

Bank Details (if applicable)

IFSC/Swift Code

5. Declaration

Declaration Statement I hereby declare that the i

Claimant Signature

Date

Note: Please attach all relevant documents, including medical reports, bills, and proof of accident (e.g., FIR, photos).