MEDICAL MALPRACTICE CLAIM FORM

The issue of this form is not to be taken as an admission of liability or a waiver of the terms, conditions or exclusions of the policy.

A) Insured

1) Name ……
2) Address ……
3) City & Pin Code……
4) Contact Person's Name & Number……
5) Email ID……
6) Period of Cover……
7) Limit of Indemnity……

B) Details of Claim or circumstances

1) Date & Time of Occurrence……
2) Place of incident……
3) Description of how the claim has arisen or why a circumstance is being notified. (PI attach a
4) Separate sheet if space is insufficient)……

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5) Have the police been informed Name of police Station
   ……
6) When did you first learn of the claim/circumstances? .....

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7) How did you learn about the claim/circumstances? .....

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C) Details of claim

If any person has made a claim against you please provide full particulars of the claimant and details of their claim lodged on you. If you have received any communication from claimants or advocates acting on their behalf, please send to us immediately.

C I – Details of claimant by whom claim is made

1) Name: ……
2) Address: ……
3) City & Pin Code: ……
4) Contact Person's Name & Number……..
5) Email ID……
6) For what ailment was treatment given: ……..
7) OPD/In Patient No: ……
8) Details of treatment provided: ……

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9) Details of claimant's Medical History:
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   (OI attach a separate sheet if required)……..
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C II- Please give all other information relevant to this claim. Use a separate sheet if required.

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D) Details of other insurances covering this incident.

1) Name of insurer:……..
2) Policy Issuing Office:……
3) Policy Number:……
4) Policy Period:……
5) Limit of INDEMNITY:……

I declare and warrant that the information given above and the information that will be given respect of this claim is correct and complete. I further agree and understand that if any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by any insured or anyone acting on behalf of an insured or with the insured's knowledge, then this policy shall be void and all benefits paid or potentially payable under it shall be forfeited.

Date: ……..

……
Signature and Seal of Insured

Place: ……..