AEGON Life

Hospital Treatment Certificate/ APS - Accidental Disability/ Dismemberment Claim

Accidental Disability / Dismemberment Claim under Policy No. ______________ on the life of

______________ (Full Name of the Life Assured)

Following information should be furnished as per Hospital Records

1) a) Name ______________

b) Age ____ Years ____ Months c) Occupation ______________

d) Address ______________

____

e) Identification mark (if any) ______________

2) a) Date of Accident D D M M Y Y Y Y

b) Time of Accident ______________ am/pm c) Place of Accident ______________

3) a) Date of Admission D D M M Y Y Y Y

b) Time of Admission ______________ c) Admission Number ______________

4) a) Nature of Accident : ☐ RTA ☐ Worksite ☐ Others ______________

b) Description of the Accident : ______________ (e.g. Road Traffic Accident, Drowning etc.)

c) Nature of Injury/ies suffered by the Insured (whether self inflicted or otherwise) ______________

e) Name and contact number of the doctor who recorded history ______________

5) If the injured was referred to you, please state the Name & Address of the Hospital/ Doctor concerned:

____

6) Did the accident occur under the influence of alcohol/drugs/narcotics or any non prescribed medicine:

____

7) Please provide details and dates of the investigations conducted during the stay in the hospital. (if so please attach copies)

Date	Investigation Details
D D M M Y Y Y Y	
D D M M Y Y Y Y	

8) Please give details of the treatment/rendered to/surgical procedure undergone by the insured.

Please furnish details in separate sheets if required

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9) What was the diagnosis arrived at in the Hospital?

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10) Please Describe the exact type of Dismemberment/Disability suffered as a consequence of the accident as mentioned above

11) Nature of impairment ☐ Temporary ☐ Permanent

12) Are you aware of any illness/ disease, disorder (including any psychic or mental disorder) which the insured was suffering from prior to this accident? If yes, give brief particulars of it

13) Date of discharge from Hospital D D M M Y Y Y Y

14) Condition at the time of discharge

15) Follow up treatment advised

16) What is the prognosis?

17) Was the accident reported to the police? ☐ Yes ☐ No

If so, please furnish the name and address of the police station and the date and time of the report:

18) Was the Disability/Dismemberment of the Insured caused solely by injuries suffered by him in the accident?

19) Any other information, which you consider, would be vital in the claim review process under this policy?

Certified that the above information is true and correct as per the records of the Hospital

Date D D M M Y Y Y Y

Signature

Name of the Doctor

Code No

Qualification and designation

Name of the Hospital

Postal Address of the Hospital

Telephone Number (with STD code)

Hospital Seal/ Stamp