Group Accident Insurance Claim Form

Instructions: Please complete all relevant sections. Attach supporting documents including medical reports, bills, and proof of incident. Submit to the HR department or your insurance provider.

1. Policyholder Information

Company/Organization Name:	_____
Policy Number:	_____

2. Insured Person's Details

Full Name:	_____
Employee/Member ID:	_____
Date of Birth:	____ / ____ / _____
Contact Number:	_____
Email Address:	_____
Address:	_____

3. Accident Details

Date & Time of Accident:	____ / ____ / _____ ____:____ (AM/PM)
Location of Accident:	_____
Describe the Accident:	
Were there any witnesses?	☐ Yes ☐ No If yes, please provide names and contact information:
Was the accident reported to authorities?	☐ Yes ☐ No If yes, please attach a copy of the report.

4. Injury and Treatment Details

Nature of Injury:	
Treatment Received:	
Name & Address of Hospital/Clinic:	_____
Date of Admission:	____ / ____ / _____
Date of Discharge:	____ / ____ / _____

5. Claim Details

Type of Benefit Claimed:	☐ Medical Expenses ☐ Partial Disability ☐ Total Disability ☐ Death Benefit
Total Amount Claimed:	$ _____

6. Declaration & Authorization

I certify that the above information is correct and complete to the best of my knowledge. I authorize the insurer to obtain further medical and other relevant information as necessary to process this claim.

Signature of Insured:	_____	**Date:**	____ / ____ / _____
Signature of Employer:	_____	**Date:**	____ / ____ / _____

Attach all relevant documents. For assistance, contact your HR department or insurance representative.