Clinical Trial Insurance – Claim Form

Policy No. _____

Period of Insurance _____

Claim Ref No: _____

The issuance of this form is not to be taken as an admission of liability. As soon as any incident is known, the incident must be notified to the Insurance Company immediately. The completion and return of this form to the Company should not be delayed if any of the particulars required cannot be immediately given , they may be forwarded to the Company afterwards as soon as possible.

Insured Particulars

1. Insured Name	
2. Correspondence Address	
3. Contact Person Details	
4. Contact Number	Mobile : Landline:

Drug/Protocol Details

Drug/Protocol Details	
Version	
Date Permission from Drug Controller for conducting trial	
Total Number of subjects (approved) for trial	

Subject Particulars:

Subject Details (affected)	Code : Initials : Gender : Male ( ) Female ( ) Age : ____ Years Dependents : Monthly Salary : Rs.
Date of consent for conducting trial by subject	
Nominee (as per consent form)	
Illness/Disease	
Date of Commencement of trial	

Incident:

Date of Adverse Event	
Place of Adverse Event (Home/Hospital)	
Date when the event came to your knowledge	
Nature of injuries	
Hospital Name where trial was being conducted	
Doctor's Name under whom trial was being conducted	
Cause of Injuries as per doctor/hospital enquiry	
Whether incident has been notified to Ethics Committee, if yes, date of notification	
Whether any formal claim has been lodged by aggrieved party/legal heirs, if yes, please provide claimed amount details also	
Whether any other trial is being conducted of same protocol, if yes, number of subjects	
What action insured has taken to avoid further occurrence of adverse event out of said protocol	
Have you engaged any legal counsel to protect your interest	
If yes, details of the advocate	Name: Contact Number
In other details/information which you wish to share about the incident	

I/We, the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect; and I/We agree that if I/We have made, or in any further declaration the Company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited, and the Policy shall be null and void.

Authorized Signatory (Name) _____

Signature _____

Place _____

Date _____