

Claim Form - Group Personal Accident Insurance

Please answer all questions completely. If the space provided is insufficient, please use a separate sheet and attach it to this form.

The issuance of this form is not to be construed as an admission of Liability

Policy Holder's Details

Name: _____

Address: _____

City: _____ Pin Code: _____

Phone No: _____ Mobile: _____ email _____

Claimant's Details

Name _____

e-Mail: _____

Address: _____

City: _____ Pin Code: _____

Phone No: _____ Mobile: _____

Relationship with Insured Person _____

Name of the Insured Person: _____

Sex: Male Female Date of Birth: ____ / ____ / ____

Occupation: _____

Employee/Member Identification No.: _____

Policy Details

Policy No.: _____

Policy Period: From _____ To _____

Details of Accident

1. Date of Accident: ____ / ____ / ____ Time ____ AM/PM

2. Place of Accident: _____

3. How did Accident occur? _____

4. Was it reported to Police? Yes No. If yes, please give the following details.

Name of Police Station: _____

FIR No: _____ Date: ____ / ____ / ____

If no, please give reasons. _____



RAHEJA QBE GENERAL INSURANCE CO. LTD.

5. Are there any witnesses to the accident? Yes No

If yes, please provide contact Details of Witnesses.

Name	Address	Contact No.	E-mail ID

6. Details of Injuries Sustained _____

7. Nature of disablement: _____

Extent of disablement: _____

Period of

Total disability - Confined to bed: From _____ To _____

Partial disability - Confined to house: From _____ To _____

If partially disabled, please give details of the daily duties of usual occupation that cannot be performed. _____

Present state of incapacity: _____

8. In case of death of the Insured Person:

Date of death: _____ / _____ / _____ Time _____ AM/PM

Was post mortem conducted? Yes No. If no, please give reasons. _____

9. Hospitalization/ Treatment details.

Name and contact details of Medical Practitioner consulted after the accident: _____

Name and contact details of other Medical Practitioner/s consulted: _____

Name and contact details of Insured Person's usual Medical Practitioner: _____

Was the Insured Person hospitalized following the accident? Yes No.

If yes, please give the name & address of the hospital. _____

Period of hospitalization: From _____ To _____

10. Estimated Claim Amount: _____

11. Where and when can a Medical Officer of Raheja QBE visit you, if necessary? _____

12. Details of any other insurance (arranged by self, spouse, parents or employer) under which claimant/deceased is covered

Name of insurer	Policy Number	Period of insurance	Coverage	Sum insured

I hereby warrant the truth of foregoing statement and sincerely declare that I have not suppressed or concealed any information that is material to this claim. I understand that false declarations may result in RQBE being able to refuse to pay a claim.

I authorize any hospital, physician or any other medical provider who has attended or examined me/insured person to furnish RQBE such details of medical history/treatment as they may require.

Date

Signature of Insured/claimant

To be completed by Employer

This is to certify that:

Mr./Ms. _____, working as _____, Employee Id No. _____
_____ covered under Group Personal Accident Policy No. _____ was on leave
for the period ___/___/___ to ___/___/_____. Mr. /Ms. _____
is covered under the policy for a sum insured of Rs. _____. The total number of employees
on the rolls as on the date of accident was _____. The above information is true to the
best of my knowledge and we agree to provide any further information that may be required.

Signature of Authorized signatory

Date:

Name & Designation of Authorized signatory:

Company Seal:

Documents to be attached to the claim form:

1. Medical Certificate forming part of the claim form.
2. Investigation reports (Laboratory tests, X- rays and reports essential for confirmation of the injury such as MRI report CAT Scan etc.)
3. First Information Report where applicable.
4. Medical bills and cash receipts.
5. Admission/ Discharge summary.
6. English translation of vernacular documents.

Medical Attendant's Certificate

1. Name of Patient: _____
2. Occupation: _____
3. How long have you known this patient? _____
4. Are you his/her usual Medical Attendant? Yes No
5. Kindly state the nature of and extent of injuries _____

6. Is the injury consistent with claimant's description of the accident? Yes No
7. Are the injuries connected with any previous accident, infirmity or disease? Yes No
If yes, please provide details. _____

8. Will the recovery be retarded due to above? Yes No
If yes, kindly provide details _____

9. When were you first consulted for this injury/disability (dd/mm/yy) _____/_____/_____
10. Please give details of other consultations –
Doctor's Name: _____
Address: _____
_____ Contact No. _____
11. Are you still treating the patient for the injury/disability? Yes No
12. Kindly provide details of treatment prescribed. _____

13. If X-ray has been done, please mention the findings and Radiologist's report. _____

14. If the patient was hospitalized please give name of the hospital. _____

15. Period of hospitalization: (dd/mm/yy) _____/_____/_____ to _____/_____/_____
16. Date & Nature of surgical procedure, if any (dd/mm/yy) _____/_____/_____.

17. Are there any complications which may retard the recovery? Yes No
If yes, please give details. _____
18. Has the patient suffered from similar injury/disability previously? Yes No
If yes, when, nature and duration of the injury/disability. _____

19. Was the patient under the influence of intoxicants or drugs at the time of accident? Yes No
20. While under your care and direction, how long was or will the patient be: _____

- a. Totally unable to perform each and every duty of his/her usual occupation
From (dd/mm/yy _____ / _____ / _____ to _____ / _____ / _____
- b. Partially disabled from performing his/her usual occupation
From (dd/mm/yy _____ / _____ / _____ to _____ / _____ / _____
- c. Nature of disablement (in case of permanent disability)
Permanent Total disability Yes No Permanent partial disability Yes No
Give details and percentage of disability. _____

21. In case of death of insured person, please give the cause of death. _____

22. Please comment on any additional factor that may prolong recovery from injury/disability. _____

I certify that I have personally attended to the named above patient and the above statements are correct.

Signature*

Qualification

Registration No.

Name

Address

Date

*Please affix official seal/stamp