# RAHEJA QBE GENERAL INSURANCE CO. LTD.

## 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 construes as an admission of Liability*

**Policy Holder's Details**

Policy No: _____ Claim No: _____

Policy Period: From_____To _____

Corporate Name:_____

Address: _____

_____

City:_____Pin Code: _____

Phone No:_____Mobile:_____email _____

Policy issued Name or Unnamed basis ☐ Named ☐ Unnamed

**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.: _____

**Claims under Which Benefits (Tick against the benefit)**

☐ Death ☐ Permanent Partial Disability ☐ Permanent Total Disability

☐ Temporary Total Disability ☐ Terrorism Extension ☐ Medical Expense

**Details of Accident**

1. Date of Accident:____/____/_____ Time_____AM/PM
2. Place of Accident: _____

   City: _____State: _____ Pin code: _____

3. How did Accident occur? _____

_____

4. Was it reported to Police? ☐ Yes ☐ No. If yes, please give the following details.
   Name and Address of Police Station: _____

_____

_____

   FIR No: _____ Date: ____/____/____

   MLC (Medico Legal Certificate) MLC report: _____
   If no, please give reasons. _____

Are there any witnesses to the accident? ☐ Yes ☐ No If yes, please provide contact Details of Witnesses.

| Name | Address | Contact No. | E-mail ID |
|---|---|---|---|
| | | | |
| | | | |

5. Details of Injuries Sustained _____

_____

6. 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: _____

7. 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. _____

_____

8. Hospitalization/ Treatment details.
   Name, Address and contact details of Medical Practitioner consulted after the accident: _____

_____

_____

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Name, Address 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 & contact of the hospital. _____

_____

Period of hospitalization: From_____To _____

9. Estimated Claim Amount: _____

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

_____

11. 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**

RAHEJA QBE GENERAL INSURANCE COMPANY LIMITED
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Telephone: +91 22 4231 3888, Fax: +91 22 4231 3777, Toll Free No. 1800-102-
Website: www.rahejaqbe.com Email: customercare@rahejaqbe.com
Corporate Identity Number: U66030MH2007PLC173129, IRDAI Reg. No. 141

# RAHEJA QBE GENERAL INSURANCE CO. LTD.

**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.

# RAHEJA QBE GENERAL INSURANCE CO. LTD.

## 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. **Are the injuries solely due to the accident or traceable to any previous injuries / disease ?** _____
6. Kindly state the nature of and extent of injuries _____

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

   _____
10. Will the recovery be retarded due to above? ☐ Yes ☐ No

    If yes, kindly provide details _____

    _____
11. When were you first consulted for this injury/disability (dd/mm/yyyy)____/____/____
12. Please give details of other consultations –

    Doctor's Name: _____

    Address: _____

    _____Contact No. _____
13. Are you still treating the patient for the injury/disability? ☐ Yes ☐ No
14. Kindly provide details of treatment prescribed. _____

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

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

    _____
17. Period of hospitalization: (dd/mm/yyyy) ____/____/____to____/____/____
18. Date & Nature of surgical procedure, if any (dd/mm/yyyy) / / .

    _____
19. Are there any complications which may retard the recovery? ☐ Yes ☐ No

    If yes, please give details. _____
20. Has the patient suffered from similar injury/disability previously? ☐ Yes ☐ No

    If yes, when, nature and duration of the injury/disability. _____

    _____

21. Was the patient under the influence of intoxicants or drugs at the time of accident? ☐ Yes ☐ No
22. 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/yyyy____/_____/_____to_____/_____/_____
    b. Partially disabled from performing his/her usual occupation
       From (dd/mm/yyyy____/_____/_____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. _____

23. In case of death of insured person, please give the cause of death. _____
24. 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