RAHEJA QBE

Raheja QBE General Insurance Company Limited
5th Floor, A Wing, Fulcrum, IA Project Road, Sahar, Andheri East, Mumbai – 400059, India.
Tel: 022-69155050 I Email: customercare@rahejaqbe.com I Website: www.rahejaqbe.com
CIN: U66030MH2007PLC173129, IRDAI Reg. No. 141

CLAIM FORM – PRAVASI BHARTIYA BIMA YOJANA

Address of Policy Issuing Office: _____

The issue of this Form does not constitute admission of liability.
Please return this Form duly completed together with relevant Reports/Bills/Certificates from concerned authorities.

POLICY NUMBER:_____ CLAIM NUMBER: _____

1	a) Name of the Emigrant (Insured Person)	
	b) Age	
	c) Address	
	d) Occupation	
	e) Passport Number	
	f) Valid upto	
	g) Details of work permit	
	h) Name of the employer/sponsor	
	i) Place of work/employment	
2	**Personal Accident Claim:**	
	a) Name of the Insured Person.	
	b) Where did the accident occur?	
	c) Give full details of injuries sustained with medical report.	
	d) Was the person under the influence of drug/alcohol at the time of accident?	
	e) Give name and address of witness to accident.	
	f) Details of Post-mortem. (In case of death of person, separate Medical Report, Post- mortem Report and Death Certificate are to be enclosed)	
	g) In case of permanent total disablement the Medical Report regarding extent of injury, the percentage of loss of physical capacity and loss of employment certificate to be enclosed.	
	h) Details of transportation of dead body to India and supporting bills.	
	i) In case the transportation of dead body is arranged by Indian Mission/Post, then please attach certificate and details of cost incurred by them.	
	j) Name of the Attendant accompanying.	
	k) Amount of cost incurred for transportation of mortal remains with supporting bills and cost of return airfare for Attendant including the particulars of place covered in the journey.	

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	Hospitalization Details:	
	a) Name of the Insured Person or family member (in respect of whom claim is made).	
	b) Present completed age.	
	c) Relationship with the Emigrant (Insured Person).	
	d) Nature of disease/illness contracted or injury sustained, including Maternity claim.	
	e) Date of injury sustained or disease/illness first detected.	
	f) Name and address of the Hospital/Nursing Home.	
	g) Date of admission.	DD / MM / YYYY
	h) Date of discharge.	DD / MM / YYYY
	i) Details of expenses incurred. (supporting Bills/Receipts/ Cash Memos along with Discharge Summary are to be enclosed to this Claim Form)	
4	a) Reasons for loss/termination of employment.	
	b) Reasons for not being employed by the Employer. (should be certified by the concerned Indian Mission/Post)	
5	Nature of litigation and amount incurred including details of litigation	
	– Name of lawyer	
	– Place of court	
	– Date of filing suit	DD / MM / YYYY
	(Please attach separate sheet for furnishing relevant details)	
6	Has the Insured Person sustained similar loss(es) prior to this loss? If yes, give details of Insurer and claim amount.	
7	Details of amount Claimed	
	A.	
	B.	
	C.	
8	Transportation and Airfare for Attendant	
	a. Actual economy class return airfare for attendant (Name of attendant , Ticket copy , Ticket Invoice and receipt)	
	b. Actual transportation cost of mortal remains(Name of attendant , medical papers / post-mortem report of deceased ,Ticket copy of attendant , Ticket Invoice and receipt of attendant)	

I/we declare that the above information furnished are correct in all aspects.

Date: DD / MM / YYYY Place:_____ Signature of Insured Person