

Claim Form

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

Policy No: _____ Claim No: _____

Policy Period: From _____ To _____

Corporate Name: _____

Address: _____

City: _____ Pin Code: _____

_____ Mobile: _____ email _____

Phone No: _____

Claimant's Details

Name _____

e-Mail: _____

Address: _____

City: _____ Pin code: _____ Phone No: _____

Relationship with Insured Person: _____ Mobile No: _____

Name of the Insured Person: _____

Sex: _____ Date of Birth: _____

Occupation/Nature of Job: _____

Employee/Member Identification No.: _____

Claims under Which Benefits (Tick against the benefit)

- ☐ Accidental Death
- ☐ Permanent Total Disability
- ☐ Permanent Partial Disablement
- ☐ Child Education

Details of Accident

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

2. Place of Accident: _____

City: _____ State: _____ Pin code: _____

3. How did Accident occur? _____

4. Nature of Injury _____

5. Are there any witnesses to the accident? Yes/ No, please provide contact Details of Witnesses.

Name	Address	Contact No.	E-mail ID

6. 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. _____

7. Details of Injuries Sustained _____

8. 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: _____

9. 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. _____

10. Hospitalization/ Treatment details.

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

_____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 _____

11. Estimated Claim Amount: _____

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

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

14. Proof of number of Dependent Child / children substantiated by proof of identity documents _____

15. 15. Age proof of the Dependent Child / children _____

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.

I/we understand that the claim may be refused if the information is untrue, inaccurate or concealed.

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:

- a. Duly completed Claim Form signed by Insured/ Nominee along with filled.
 - i. Attending Physician's Statement
 - ii. Claimant's Statement - Please provide brief details of accident/illness and enclose with claim form.
- b. Photocopy of Policy Schedule /Certificate of Insurance
- c. Copies of medical documents supporting the disability and treatment taken related to the same.
- d. Original Investigation Reports and copies of reports, X - Ray films supporting the accidental injury. Post-Operative X-ray films, if any
- e. Disability Certificate (Not mandatory - as per the discretion of the insurer)
 - i. For Physical Disabilities related with separation of limbs or complete loss of organs - Copy of Disability Certificate issued by Orthopaedic Surgeon mentioning the type and percentage of disability. -Disability certificate to be issued by government doctor
 - ii. For Physical Disabilities NOT related with separation of limbs or complete loss of organs - Copy of Disability Certificate issued by a Government Doctor / Disability Board / Panel only
 - iii. For Non - Physical Disabilities - Copy of Disability Certificate issued by a Government Doctor / Disability Board / Panel only for the related specialty (e.g., Loss of memory, sense organs, vision, hearing etc.)
- f. In case of Employer Employee Group Policy
 - i. Leave Records with seal and signature of Authorized signatory of the organization specifying the period of leave and reason for the same.
 - ii. Photocopy of 12 months' Salary slips/ Form 16/26/ITR as per insurer discretion confirming the loss of monthly income
 - iii. A copy of the Termination Employment Letter from Employer (if applicable)
 - iv. Letter from employer to certify that the Claimant is not being paid during the period of disability.
 - v. Employee ID card

- vi. Credit card statement for the policy period
- vii. First Information Report and Final Police report, wherever necessary.
- viii. Bills and receipt towards expenses relevant to funeral ceremony / repatriation of mortal remains.
- ix. Loan Certificate/Amortization Schedule prepared by the Bank/ Financial Institution at the time of
- x. disbursement of Loan showing details of the Loan/EMIs, Principal Outstanding, etc.,
- xi. Death certificate, wherever applicable.
- xii. Copy of Photo ID and Address Proof of Insured Member for whom Claim is lodged.
- xiii. Legal Heir Certificate containing affidavit and indemnity bond both duly signed by all legal heirs and notarized (Mandatory if Nominee name is not mentioned on policy schedule/Certificate of Insurance).
- xiv. Authorization Letter - Authorization letter has to be submitted if you are authorizing another party to handle the claim (including collection of cheque) on your behalf.
- xv. Consultation papers for all past and ongoing treatments.
- xvi. NEFT/Bank Details (to enable direct credit of claim amount in bank account) and cancelled cheque.
- xvii. KYC (Identity proof with Address – Pan card, Aadhar card, CKYC form) of the proposer.
- g. In case of Hospital Daily Cash policy
 - i. Claim Form Duly Filled and Signed (Original)
 - ii. Copy of attested Hospital summary / Discharge Summary
 - iii. Final Hospital Bill with Bill break up and receipt (photocopy)
 - iv. Copy of KYC documents (Photo ID proof, Pan Card, Aadhar Card etc.)
 - v. Cancelled cheque for NEFT payment
 - vi. Disability certificate from a Medical Practitioner or Hospital confirming the extent and nature of disability
 - vii. Hospital Treatment papers
 - viii. Any other related documents

Medical Attendant's Certificate

- 1 Name of Patient: _____
- 2 Occupation: _____
- 3 Are you his/her usual Medical Attendant? ☐ Yes ☐ N
- 4 How long have you known this patient? _____
- 5 Are you his/her usual Medical Attendant? _____
- 6 Are the injuries solely due to the accident or traceable to any previous injuries / disease? _____
- 7 Kindly state the nature of and extent of injuries _____

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

- 11 Will the recovery be retarded due to above? ☐ Yes ☐ No
If yes, kindly provide details

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

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

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

18. Period of hospitalization: (dd/mm/yyyy) / / to / /

19. Date & Nature of surgical procedure, if any (dd/mm/yyyy)

20 Are there any complication which may retard the recovery? Yes No

If yes, please give details. _____

21 Has the patient suffered from similar injury/disability previously? ☐ Yes ☒ No

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

22 Was the patient under the influence of intoxication or drugs at the time of accident? Yes / No

23 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: _____

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

25 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*
Name

Qualification
Address

Registration No.

Date

*Please affix official seal/stamp