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
Source: Certified as Great Place to Work by the Great Place to Work Institute in June 2025

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 construes 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)

☐ Death ☐ Permanent Partial Disability ☐ Permanent Total Disability
☐ Temporary Total Disability ☐ Terrorism Extension ☐ Medical Expense
☐ Hospital Daily Cash

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

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

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Great Place To Work. Certified JUN 2025–JUN 2026 INDIA

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 _____ / /

Your Kind of Insurance

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* Qualification Registration No.
Name Address

Date

*Please affix official seal/stamp