

Claim Form – Hospital Daily Cash 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

Policy No: _____ Claim No: _____

Policy Period: From _____ To _____

Corporate Name: _____

Address: _____

City: _____ State: _____ Pin code: _____

Mobile Number: _____ Email ID: _____

Phone No: _____

Policy issued Name or Unnamed basis Named Unnamed

Claimant's Details

Name: _____

Email: _____

Address: _____

City: _____ State: _____ Pin code: _____

Mobile Number: _____ Email ID: _____

Phone No: _____

Relationship with Insured Person: _____

Name of the Insured Person: _____

Sex: _____ Date of Birth: _____

Employee/Member Identification No: _____

Claims under Which Benefits (Tick against the benefit)

- 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. Was it reported to Police? Yes_____ No_____ if yes, please give the following details.

Name and address of Police Station: _____

FIR No: _____ Date: _____

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 _____

7. In case of death of the Insured Person:

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

Was postmortem conducted? ___Yes___ No if not, please give reasons _____

8. 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 details of the hospital.

Period of hospitalization: From _____ To _____

9. Estimate of 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 employee) 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 Disability Income Protected Group Insurance Policy No _____ was on leave for the period _____ To _____

Mr./Mrs. is covered under the policy for a sum insured of Rs _____ The total number of employees on the rolls as on 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.
- b) ii. Claimant's Statement - Please provide brief details of accident/illness and enclose with claim form.
- c) Photocopy of Policy Schedule /Certificate of Insurance
- d) Copies of medical documents supporting the disability and treatment taken related to the same.
- e) Original Investigation Reports and copies of reports, X - Ray films supporting accidental injury. Post-Operative X-ray films if any
- f) Bills and receipt towards expenses relevant to funeral ceremony / repatriation of mortal remains.
- g) Copy of Photo ID and Address Proof of Insured Member for whom Claim is lodged.
- h) 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.
- i) Consultation papers for all past and ongoing treatments.
- j) NEFT/Bank Details (to enable direct credit of claim amount in bank account) and cancelled cheque.
- k) KYC (Identity proof with Address – Pan card, Aadhar card, CKYC form) of the proposer.

Medical Attendant's Certificate

1. How long have you known this patient? _____
2. Are you his/her usual Medical Attendant? Yes _____ No _____
3. Name of Patient: _____
4. Occupation: _____
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 _____
If yes, please provide details _____
9. Will the recovery be retarded due to above? Yes _____ No _____
If yes, kindly provide details _____
10. When were you first consulted for this injury/disability (DD/MM/YYYY) _____
11. Please give details of other consultations-
Doctor's Name: _____
Address: _____
Contact No: _____
12. Are you still treating the patient for the injury/disability? Yes _____ No _____
13. Kindly provide details of treatment prescribed. _____
14. If x-ray has been done, please mention the findings and Radiologist's report: _____

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

16. Period of hospitalization : (DD/MM/YYYY) _____
17. Date & Nature of surgical procedure, if any (DD/MM/YYYY) _____
18. Are there any complications which may retard the recovery? Yes _____ No _____
If yes, please give details. _____
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/YYYY) _____
 - b. Partially disabled from performing his/her usual occupation from (DD/MM/YYYY) _____
 - c. Nature of disablement (in case of permanent disability)
Permanent Total Disability – Yes _____ No _____ Permanent Partial Disability – Yes _____ No _____
Given 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 : _____

Name: _____

Qualification: _____

Address: _____

Registration No: _____

Date : _____

Please affix official seal/stamp