

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)

- Death
- Permanent Total Disability
- Permanent Partial Disablement
- Temporary Total Disablement
- Hospitalisation Expenses due to Accident
- Education Grant

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 _____

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

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