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 – Wage Compensation Policy - Group

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: _____

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Employee/Member Identification No: _____

Claims under Which Benefits (Tick against the benefit)

- ○ Sickness Hospitalization Cash
- ○ Accident Hospital Cash
- ○ Accidental Death
- ○ Day Care Procedure Cash
- ○ Convalescence Benefit
- ○ Loss of Income
- ○ International Emergency Benefit
- ○ Time Deductible
- ○ Double benefit option

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_____

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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_____

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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.
l) MLC/FIR Report/Postmortem Report (if applicable and conducted) duly attested by concern authority.
m) Proof of loss of income (Applicable for Loss of income cover, if opted). Salary Slip for Salaried person and proof of occupation for self-employed person.

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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/YYY)_____
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/YYY)_____
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._____

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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