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

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: _____ Pincode: _____

Mobile: _____ Email: _____

Phone No: _____

Policy issued Name or Unnamed basis Named Unnamed

Claimant's Details

Name: _____

E-Mail: _____

Address: _____

_____

City: _____ Pin code: _____

Phone No: _____ Mobile no: _____

Relationship with Insured Person: _____

Name of the Insured Person: _____

Sex: Male Female

Occupation: _____

Date of Birth: _____

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

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Details of Accident

1. Date of Accident:

2. Place of Accident:

Time AM/PM

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: _____

MLC (Medico Legal Certificate) MLC report: _____

If no, please give reason: _____

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:

_____

_____

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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:

_____

7. 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.

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 of the hospital.

_____
_____

Period of hospitalization: From _____ TO _____

9. Estimated Claim Amount:

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

_____
_____

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11. 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.

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:

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Documents to be attached to the claim form:

1. Medical Certificate forming part of the claim form.

2. Investigation reports (Laboratory tests, X- rays and reports essential for confirmation of the injury such as MRI report CAT Scan etc.)

3. First Information Report where applicable.

4. Medical bills and cash receipts.

5. Admission/ Discharge summary.

6. English translation of vernacular documents.

MEDICAL ATTENDANT'S CERTIFICATE

1. Name of Patient:
2. Occupation:
3. How long you have known this patient:
4. Are you his/her usual Medical attendant: Yes No
5. Are the injuries solely due to the accident or traceable to any previous injuries / disease?
   _____
   _____
6. Kindly state the nature 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
9. If yes, please provide details.
10. Will the recovery be retarded due to above? Yes No
    If yes, kindly provide details
11. When were you first consulted for this injury/disability (dd/mm/yyyy)
12. Please give details of other consultations —
    Doctor's Name: _____ Address: _____
    Contact No.
13. Are you still treating the patient for the injury/disability? Yes No
14. Kindly provide details of treatment prescribed.

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

    _____

    _____

16. If the patient was hospitalized please give name of the hospital.

    _____

    _____

17. Period of hospitalization: (dd/mm/yyyy) / / to / /
18. Date & Nature of surgical procedure, if any (dd/mm/yyyy) / /

    _____

    _____

19. Are there any complications which may retard the recovery? Yes No
    If yes, please give details.

20. Has the patient suffered from similar injury/disability previously? Yes No
    If yes, when, nature and duration of the injury/disability.

21. Was the patient under the influence of intoxicants or drugs at the time of accident? Yes No

22. 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.

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

24. 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: Qualification: Registration No:

Name: Address:

Date:

*Please affix official seal/stamp.