RAHEJA QBE GENERAL INSURANCE CO. LTD.

Claim Form - Group Personal Accident 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 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:

Policy issued Name or Unnamed basis ☐Named ☐Unnamed

Claimant's Details

Name _____

e-Mail: _____

Address: _____

_____

City: ___Pin Code: _____

Phone No: Mobile: _____

Relationship with Insured Person _____

Name of the Insured Person: _____

Sex: ☐ Male ☐ Female Date of Birth: __/__/_____

Occupation: _____

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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

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: ____/_____/_____

MLC (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. _____

_____

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? _____

    _____

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.

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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**

RAHEJA QBE GENERAL INSURANCE COMPANY LIMITED
Fulcrum, 501 & 502, A wing, 5th Floor, International Airport project road, Sahar, Andheri -East, Mumbai 400059
Telephone: +91 22 4231 3888, Fax: +91 22 4231 3777, Toll Free No. 1800-102Website: www.rahejaqbe.com Email: customercare@rahejaqbe.com
Corporate Identity Number: U66030MH2007PLC173129, IRDAI Reg. No. 141

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:

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

_____

_____

3. How long have you known this patient?
4. Are you his/her usual Medical Attendant? ☐ Yes ☐ No
1. Name of Patient:
2. 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
9. If yes, please provide details. _____

_____

10. Will the recovery be retarded due to above? ☐ Yes ☐ No

    If yes, kindly provide details

_____

When were you first consulted for this injury/disability (dd/mm/yyyy) / /

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11.

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. ___

    _____

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. ____

RAHEJA QBE GENERAL INSURANCE CO. LTD.

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