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 – RQBE Disability Income Protect Group 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: _____

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Claims under Which Benefits (Tick against the benefit)

- Death
- Permanent Partial Disability
- Permanent Total Disability
- Temporary Total Disability
- Terrorism Extension
- Medical Expense Monthly Temporary Disability Income
- Monthly Temporary Disability Income
- Lump-sum Permanent Disability Income
- Credit Card Minimum Amount Protection
- Loan Protection
- Personal Expenses Assistance

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.

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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.

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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 RQBE Disability Income Protect - 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:

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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 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

g. Credit card statement for the policy period

h. First Information Report and Final Police report, wherever necessary.

i. Bills and receipt towards expenses relevant to funeral ceremony / repatriation of mortal remains.

j. Loan Certificate/Amortization Schedule prepared by the Bank/ Financial Institution at the time of

k. disbursement of Loan showing details of the Loan/EMIs, Principal Outstanding, etc.,

l. Death certificate, wherever applicable.

m. Copy of Photo ID and Address Proof of Insured Member for whom Claim is lodged.

n. 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).

o. 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.

p. Consultation papers for all past and ongoing treatments.

q. NEFT/Bank Details (to enable direct credit of claim amount in bank account) and cancelled cheque.

r. KYC (Identity proof with Address – Pan card, Aadhar card, CKYC form) of the proposer.

s. Form 16/26/ITR as per insurer discretion confirming the loss of monthly income

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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._____

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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