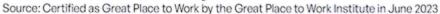


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Claim Form - Group Personal Accident Insurance

Please answer all questions completely. If the space provided is insufficient, please use a separate sheet and attach it to this form.

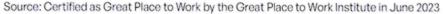
The issuance of this form is not to be construes as an admission of Liability

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 N	amed 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 -
Occupation:	Birth:

Your Kindof Insurance-



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Employee/Member Identification No.: Claims under Which Benefits (Tick against the benefit) Permanent Partial Disability Permanent Total Disability Death Terrorism Extension Temporary Total Disability Medical Expense **Details of Accident** 1. Date of Accident: / / Time AM/PM 2. Place of Accident: City:______ Pin code: _____ 3. How did Accident occur? _____ 4. Was it reported to Police? Tyes 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 E-mail ID Contact No. Details of Injuries Sustained





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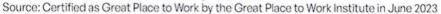


6.	Nature of disablement:Extent of disablement:					
	Period of Total disability - Confined to bed:	From	To			
	Partial disability - Confined to house:					
	If partially disabled, please give details of the daily duties of usual occupation that cannot be					
	performed.					
	Present state of incapacity:					
7.	In case of death of the Insured Person	n:				
	Date of death: / /		Time	AM/PM		
	Was post mortem conducted? - Ye	es No. If no, plea	se give reasons			
8.	Hospitalization/ Treatment details. Name, Address and contact details of Name, Address and contact details of					
	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		То			
9.	Estimated Claim Amount:					
10.	Where and when can a Medical Office	er 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	Coverage	Sum insured
		Insurance		

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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6. English translation of vernacular documents.





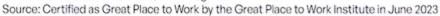
To be completed by Employer

Thi	s is to certify that:		
Mr.	/Mscovered under Group Personal Accid	, working as lent Policy No	, Employee Id No.
for	the period//	to/ . Mr. /Ms.	
is c	covered under the policy for a sum insu	red of Rs	The total number of employees
on	the rolls as on the date of accident was	. The ab	ove information is true to the
bes	st of my knowledge and we agree to pro	vide any further informa	ation that may be required.
Sig	nature of Authorized signatory		Date:
Na	me & Designation of Authorized sign	atory:	
Co	mpany Seal:		
Do	cuments to be attached to the claim	form:	
1.	Medical Certificate forming part of the	claim form.	
2.	Investigation reports (Laboratory tests injury such as MRI report CAT Scan e		sential for confirmation of the
3.	First Information Report where applica	ble.	
4.	Medical bills and cash receipts.		
5.	Admission/ Discharge summary.		





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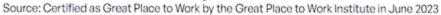


Medical Attendant's Certificate

3.	How long have you known this patient?
l.	Are you his/her usual Medical Attendant? Yes No Name of Patient:
<u>.</u> .	Occupation:
	Are the injuries solely due to the accident or traceable to any previous injuries / disease ?
i.	Kindly state the nature of and extent of injuries
	Is the injury consistent with claimant's description of the accident? ¬ Yes No
	Are the injuries connected with any previous accident, infirmity or disease? Yes No
	If yes, please provide details
0.	Will the recovery be retarded due to above? "Yes No
	If yes, kindly provide details
1.	When were you first consulted for this injury/disability (dd/mm/yyyy) 7 /
2.	Please give details of other consultations –
	Doctor's Name:
	Address:
_	Contact No
	Are you still treating the patient for the injury/disability? \(\text{Yes}\) No
4.	Kindly provide details of treatment prescribed
5.	If X-ray has been done, please mention the findings and Radiologist's report.
6.	If the patient was hospitalized please give name of the hospital.
7.	Period of hospitalization: (dd/mm/yyyy)/ to /
8.	Date & Nature of surgical procedure, if any (dd/mm/yyyy) / /
	of In



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19	. Are there any complications which may retard the recovery? ☐Yes No				
	If y	ves, please give details.			
20	На	Has the patient suffered from similar injury/disability previously? □Yes No			
		es, when, nature and duration of the injury/disability			
21.	Wa	s the patient under the influence of intoxicants or drugs at the time of accident? Yes No			
22.	Wh	nile 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/toto			
	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 TYes No Permanent partial disability Yes No			
	Give details and percentage of disability.				
23.	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.					
I ce	ertify	that I have personally attended to the named above patient and the above statements are			
cor	rect				
Signature* Name					
iva	пе	Address			
Da	Date				
*Pl	*Please affix official seal/stamp				

