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
Source: Certified as Great Place to Work by the Great Place to Work Institute in June 2023

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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Great Place To Work. Certifie JUNE 2023 – JUNE INDIA

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 _____

_____

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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: 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**

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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.

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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

_____

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. ____

_____

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) / /

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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. _____

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