

Claim No.: _____

PERSONAL ACCIDENT - CLAIM FORM

Issuance of this form does not imply acceptance of the liability

Please submit the completely filled claim form within thirty days from the date of loss along with the relevant claim documents.

*Policy No.			
Period From	DD / MM / YYYY	Period To	DD / MM / YYYY
Date of Registration	DD / MM / YYYY	Area Office Code/ Service Centre Code	
Broker/Agent Name		Code	
Agent Mobile No.		Agent Email ID	
1. *Name of the Insured			
2. *Customer ID			
3. *Address of the Insured			
Plot No./Flat No.		Building Name	
Road		Area	
City		*Pin Code	
State		*Phone No.	
PAN No.			
*E-mail Id			
Profession/Occupation	<input type="checkbox"/> Business <input type="checkbox"/> Profession <input type="checkbox"/> Salary <input type="checkbox"/> Agricultural Income <input type="checkbox"/> Savings <input type="checkbox"/> Others		
Monthly Income	<input type="checkbox"/> Upto ₹ 20,000 <input type="checkbox"/> ₹ 20,001 to ₹ 50,000 <input type="checkbox"/> ₹ 50,001 to ₹ 1,00,000 <input type="checkbox"/> ₹ 1,00,001 and above		
4. Profession or Occupation			
Policy details			
Sum Insured		Table of Cover	
Details of Accident			
5. a) Name of the Insured Person dead/injured in the accident			
b) Relationship with the employee/member			
c) *Employee/member identification no.		Self/Spouse/Children	
6. a) Date of accident:	DD / MM / YYYY	b) Time of accident:	HH / MM AM/PM
c) Place of accident:			
d) Name & address of the witness:			



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022 4890 3009 (Paid)



74004 22200 (WhatsApp)

7. Particulars of the accident:	
<div></div> <div></div>	
8. Nature of injury received (if to limb or eye state whether right or left)	
<div></div> <div></div>	
9. a) Nature of disablement	
<div></div>	
b) Extent of disablement	
<div></div>	
c) Period of temporary total disablement	From DD / MM / YYYY To DD / MM / YYYY
d) Present state of incapacity	
<div></div> <div></div>	
10. Name and address of surgeon in attendance	
<div></div> <div></div>	
11. Where and when can a Medical Officer of this Company visit you, if necessary?	
<div></div>	
12. a) Are you insured in any other office or offices of the Company or any other company, granting compensation for accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Present state of incapacity	
<div></div> <div></div>	

POLICYHOLDER BANK DETAILS			
13. Name of the Bank Account Holder:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	FIRST	MIDDLE
14. Bank Account No.:	15. Account:	<input type="checkbox"/> Saving	<input type="checkbox"/> Current
16. Name of the Bank:			
17. Branch:			
18. MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank):			
19. IFSC Code (11 character code appearing on your cheque leaf):			
<input type="checkbox"/> I understand that any refund due on the premium payment / any payment / claims to be directly credited to my aforesaid Bank Account.* *As per IRDAI, its mandatory that all payments made to the insured are only through electronic mode. Note: Please attach original cancelled cheque and a copy of PAN card for verification of the particulars provided in this regard.			

AADHAAR BASED PAYMENT (FOR REIMBURSEMENT CLAIMS)	
Aadhaar Card No.:	(Note: Self attested Aadhaar card copy to be submitted)
<input type="checkbox"/> I wish to collect claim reimbursement directly in my Bank account linked with my aforementioned Aadhaar Card. I understand that the claim amount shall be credited directly in my latest Bank account linked with my Aadhaar Card. I/We hereby declare that the details given above are true and correct to the best of my belief and knowledge. In the event above information or any part thereof is found incorrect, I agree that all right under the policy will be forfeited. I agree to provide additional information to the Company if required. I will indemnify and hold harmless the Company due to any loss arising out of misstatement in this form and am willing if required, to make a statutory Declaration before a Justice of the Peace of the truth of the whole of the foregoing statement or any other statement I may make in connection with this claim. I further agree and undertake not to receive from Reliance General Insurance Company Limited any rebate other than that mentioned in the published prospectus in accordance with the provisions Section 41 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015.	

Witness:	
Name: _____	_____
	Signature
Name: _____	
Address: _____	
Date: _____	Signature of Insured Person/Claimant

* Mandatory details to be filled

MEDICAL CERTIFICATE (TO BE FILLED BY TREATING DOCTOR)	
(Claim must be supported by medical evidence furnished by the Insured at his/her expense)	
1. a) Name of Claimant	
b) Age	
2. a) Nature and cause of accident	
b) If to eye or limb, state left or right	
c) Whether the appearance of the injuries are consistent with the account given of the accident	
3. Date on which you first attended claimant for this injury	
4. Has claimant been totally prevented from attending to any portion of his business? If so, for how long?	
5. Is claimant suffering from any disease or illness apart from his injury and is there any illness by circumstances which may tend to retard recovery? If so, give particulars	
6. Present condition	
7. How long from the happening of the accident do you consider	
a) Total disablement will last	
b) Partial disablement will last	
Having personally examined the above named Claimant, I certify that the above statements are correct and that the injured person/ Claimant is necessarily disabled by the accident referred to.	
Name: _____	
Qualification: _____	
Address: _____	
Date: _____	Signature

PEP DECLARATION:	
Are you a Politically Exposed Person (PEP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please mention the position held	
Is any of your close relation or family member a PEP?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please mention the name and relation and the position held by such close relative/family member.	

I hereby declare that in future if me, any of my close relatives or any of my family member attains a position of PEP then I shall confirm the same to Reliance General Insurance Co. Ltd as a mandate. I understand that this is a crucial information under the PMLA Rules and AML/CFT Guidelines and shall confirm that the answers given by me is true. In case the company comes to know that this is a misrepresentation and concealment of information then the policy shall be put on hold for scrutiny by the company and I shall be solely responsible for the same.

Note :

"Politically Exposed Persons" (PEPs) shall have the meaning assigned to it under sub clause (db) of clause (1) of Rule 2 of the Prevention of Money Laundering (Maintenance of Records) Rules, 2005."

(db) "Politically Exposed Persons" (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials".

AML Guidelines

1. I/We hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been /will be paid out of proceeds of crime related to any of the offense listed in Prevention of Money Laundering Act,2002.
2. I Understand that the Company has the right to call for document to established sources of funds.
3. The Insurance Company has right to cancel the insurance contract in case I am/have been found guilty by competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India.

Place: _____

Date: _____

Signature of Proposer

GENERAL DECLARATION:

I understand that as per the new AML/CFT Guidelines issued Reliance General Insurance Co. Ltd will be verifying my details pertaining to KYC and PAN provided at the time of proposal.

I further, do hereby agree and consent that in the case of the event of a mismatch of information provided by me in the proposal form, identification proof, and address proof at the time of issuance of the policy. I request Reliance General Insurance Company Limited to issue the policy with the details appearing as per my proposal form. I will be solely responsible for any consequences arising out of the difference in detail given by me during the verification of supporting documents provided by me at the time of issuance of the policy or otherwise.

DOCUMENT CHECK LIST FOR PERSONAL ACCIDENT CLAIM SUBMISSION

Sr. No.	Accidental Death Claim Document Type	Yes/No
A.	Duly filled and signed Claim form	
B.	Original/Attested copy of Death Certificate	
C.	Attested copy of Post Mortem Examination report	
D.	In Case of Accident - Copy of Medico Level Certificate from hospital	
E.	Copy of Photo ID proof of Insured person (Employee/Member ID card)	
F.	Attested copy of FIR of local police station or Detailed Police Information note or Inquest Panchnama / Spot Panchnama (if applicable)	
G.	Original Cancelled Cheque in CTS 2010 format (Printed account number, IFSC code, Printed name) Mandatory. In case the name is not printed on cheque leaf, scanned copy of 1st page of passbook or the authorized bank statement.	
H.	For claimed amount above 1 lac self attested copy of PAN Card / Form 60 of Insured is mandatory & for below 1 lac claimed amount copy of Photo identity proof (PAN Card / Form 60, Aadhaar Card, Voter ID etc.) is mandatory	

Sr. No.	Accidental Injury Claim Document Type	Yes/No
I.	PTD (Permanent Total Disability) & PPD (Permanent Partial Disability)	
A.	Duly filled and signed Claim form	
B.	Complete treatment record like Discharge summary, Consultation papers with supporting Investigation reports like X-ray / MRI etc.	
C.	In Case of Accident- Copy of Medico Level Certificate from hospital	
D.	Attested copy of FIR of local police station or Detailed Police Information note or Inquest Panchnama / Spot Panchnama (if applicable)	
E.	Coloured and clear photograph of Disabled person showing the disability	
F.	Income proof like Pay slips/Salary slips prior to the Date of loss.	
G.	Copy of Employee/Member Photo ID proof	
H.	Original Cancelled Cheque in CTS 2010 format (Printed account number, IFSC code, Printed name) Mandatory. In case the name is not printed on cheque leaf, scanned copy of 1st page of passbook or the authorized bank statement.	
I.	For claimed amount above 1 lac self attested copy of PAN Card /Form 60 of Insured is mandatory & for below 1 lac claimed amount copy of Photo identity proof (PAN Card/ Form 60, Aadhaar Card, Voter ID etc.) is mandatory	

II	TTD (Temporary Total Disability)	Yes/No
A.	Duly filled and signed Claim form	
B.	Medical Certificate confirming the Disability period and the probable date to resume duty/service	
C.	Complete treatment record like Discharge summary, Consultation papers with supporting Investigation reports like X-ray/MRI etc.	
D.	In Case of Accident- Copy of Medico Level Certificate from hospital	
E.	Attested copy of FIR of local police station or Detailed Police Information note or Inquest Panchnama / Spot Panchnama (if applicable)	
F.	Leave Certificate from the Employer mentioning the leave dates	
G.	Income proof like Pay slips/Salary slips prior to the Date of loss.	
H.	Copy of Employee/Member Photo ID proof	
I.	Original Cancelled Cheque in CTS 2010 format (Printed account number, IFSC code, Printed name) Mandatory. In case the name is not printed on cheque leaf, scanned copy of 1st page of passbook or the authorized bank statement.	
J.	For claimed amount above 1 lac self attested copy of PAN Card /Form 60 of Insured is mandatory & for below 1 lac claimed amount copy of Photo identity proof (PAN Card/Form 60, Aadhaar Card, Voter ID etc.) is mandatory	

Please note the above list is only indicative. Insured/ Claimant may have to submit additional documents/information if required.

RCare Address:	
Rcare Health: Reliance General Insurance, No.1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad - 500081. Email: rgicl.rcarehealth@relianceada.com.	