RELIANCE
General Insurance

reliancegeneral.co.in
1800 3009

Personal Accident
Claim Form

Issuance of this form does not imply acceptance of the liability

Please return the form completed within Fourteen days of the loss together with the relevant vouchers, documents etc.

Policy No. _____ Claim No. _____

Date of Registration d d m m y y y y

Area Office Code/Service Centre Code _____

Broker/Agent Name _____ Code _____

1. Name of the Insured _____
2. Customer ID _____
3. Address of the Insured
   Plot No./Door No. _____ Building name _____
   Road _____
   Area _____
   City _____ Pin Code _____
   State _____
   Phone No. _____ **Aadhaar (UIDAI) No.** _____
   PAN No. _____ E-mail ID _____
   Profession/Occupation ☐ Business ☐ Profession ☐ Salary ☐ Agricultural Income ☐ Savings ☐ Others
   Mmonthly Income ☐ Upto ₹ 20,000 ☐ ₹ 20,001 to ₹ 50,000 ☐ ₹ 50,001 to ₹ 1,00,000 ☐ ₹ 1,00,000 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: d d m m y y y y b) Time of accident: h h m m AM/PM

   c) Place of accident: _____

   d) Name & address of the witness:

   _____

   _____

7. Particulars of the accident:

   _____

   _____

   _____

   _____

RCare Health: Reliance General Insurance, No.1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad 500081.
Reliance General Insurance Company Limited.
Registered Office: 19, Reliance Centre, Walchand Hirachand Marg, Ballard Estate, Mumbai 400001.
Corporate Office: 570, Rectifier House, Naigaum Cross Road, Next to Royal Industrial Estate, Wadala (W), Mumbai 400031.
Corporate Identity Number U66603MH2000PLC128300.

An ISO 9001:2008
Certified Company

8. Nature of injury received (if to limb or eye state whether right or left)

_____

_____

9. a) Nature of disablement

_____

b) Extent of disablement

_____

c) Period of temporary total disablement From d d m m y y y y To d d m m y y y y

d) Present state of incapacity

_____

10. Name and address of surgeon in attendance

_____

_____

11. Where and when can a Medical Officer of this Company visit you, if necessary?

_____

12. a) Are you insured in any other office or offices of the Company or any other company, granting compensation for accident? ☐ Yes ☐ No.

b) If so state name and address of company or companies and amount of insurance

_____

_____

Policyholder Bank Details

13. Name of the Bank Account Holder ☐ Mr. ☐ Mrs. ☐ Ms. F I R S T M I D D L E L A S T

14. Bank Account No.: 15. Account: ☐ Saving ☐ 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)

I Wish: ☐ Any refund due on the premium payment / any payment / claims will be directly credited to my aforesaid Bank Account.*

*As per IRDAI, its mendatory that all payments made to the insured 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)

☐ 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 forefeited.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 _____

Signature of Insured Person/Claimant

Name: _____

Address: _____

_____

Date: _____

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.

Signature: _____

Name: _____

Qualification: _____

Address: _____

_____

List of Documents Attached

SN	Description	Bill No.	Amount

RGI/MCOM/MI-05/CF/Ver. 1.3/070815