RELIANCE
General Insurance

reliancegeneral.co.in
1800 3009

Reliance Inland Travel Care Policy

Claim Form B

Personal Accident/Accidental Death & Dismemberment-Common Carrier

Details of Accident

When did the accident happen ? ____ a.m./p.m.

Date of death ____ Time of death ____ a.m./p.m.

Location ____

Please provide the necessary details about the accident ____

Please state the nature and extent of loss ____

Please state the amount claimed ____

Details of Witnesses

Witness 1

Name ☐ Mr. ☐ Mrs. ____

Address for Communication

Flat Building ____

Road/Street/Sector ____ Area ____

Taluka/Village/District/City ____ Pin Code ____

State ____ Country ____

Phone ____ Mobile ____

Email ____ Fax ____

Witness 2

Name ☐ Mr. ☐ Mrs. ____

Address for Communication

Flat Building ____

Road/Street/Sector ____ Area ____

Taluka/Village/District/City ____ Pin Code ____

State ____ Country ____

Phone ____ Mobile ____

Email ____ Fax ____

Treatment Details

Please specify whether the Insured Person was hospitalised for the treatment of injury due to the accident? ☐ Yes ☐ No

If yes, period of Hospitalisation From d d m m y y y y To d d m m y y y y

Please provide name of the Hospital /Nursing home where the Insured Person was treated for the injury sustained due to the accident? ____

Address for Communication

Flat Building ____

Road/Street/Sector ____ Area ____

Taluka/Village/District/City ____ Pin Code ____

State ____ Country ____

Phone ____ Fax ____

Please provide the name of Physician/Surgeon who attended on the Insured Person during the treatment for the injury sustained due to the accident?

Address for communication

Flat Building

Road/Street/Sector Area

Taluka/Village/District/City Pin Code

State Country

Phone Mobile

Email Fax

Have the Police Authorities been informed of this accident ?

Have the following documents been submitted ?

a. Copy of FIR ☐ Yes ☐ No c. Police Report ☐ Yes ☐ No

b. Death Certificate ☐ Yes ☐ No d. Post Mortem Report (in case of accidental death) ☐ Yes ☐ No

Attending Doctor/Physician's Statement (To be filled up the by Attending Doctor/Physician)

Name of Insured Person

Age

Address

Flat Building

Road/Street/Sector Area

Taluka/Village/District/City Pin Code

State Country

Phone Mobile

Email Fax

Please state nature of the accident and details of injuries sustained

Does the cause of accident as stated by the Insured Person tally with the injuries noticed by you?

Are the injuries solely due to the accident or traceable to any previous injuries / disease / infirmities?

Was the Insured Person suffering from any disease/injury which may have contributed to the accident or likely to aggravate his/her condition.

Was the Insured Person hospitalized? If so for what period? From d d m m y y y y To d d m m y y y y

Please provide the details of treatment given and operations performed, if any?

Was he/she under the influence of intoxicants or drugs at the time of accident?

Has this accident been reported to the police authorities? If yes

Case No. Police Station

Name of Attending Doctor/Physician Dr.

Address

Flat Building

Road/Street/Sector Area

Taluka/Village/District/City Pin Code

State Country

Phone Mobile

Email Fax

Attending Doctor/Physician's Signature Date d d m m y y y y Regn. No.

Proposer's Bank Details

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

Bank Account No.: Account: ☐ Saving ☐ Current

Name of the Bank

Branch

MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)

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 IRDA, its mendatory that all payments made to the insured only through electronic mode.

RGI/MCOM/HL-06/CF-B/Ver. 1.7/231214