RELIANCE GENERAL INSURANCE
A RELIANCE CAPITAL COMPANY

reliancegeneral.co.in
1800 3009

Claim No.

Employees Compensation Insurance Policy
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 d d m m y y y y Period To d d m m y y y y

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. Business/Occupation
4. *Address of the Insured

Plot No./Flat No. Building name

Road

Area

City *Pin Code

State

*Phone No.

Aadhaar (UIDAI) No./VID No. PAN No.

*E-mail Id

Profession/Occupation ☐ Business ☐ Profession ☐ Salary ☐ Agricultural Income ☐ Savings ☐ Others

Monthly Income ☐ Upto ₹ 20,000 ☐ ₹ 20,001 to ₹50,000 ☐ ₹ 50,001 to ₹1,00,000 ☐ ₹ 1,00,001 and above

5. Details of the injured person

a) Name

b) Local/Permanent Address

c) Age/Sex

d) State nature of work for which the injured person was employed

RCare Health: Reliance General Insurance, No.1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad 500081.

IRDAI Registration No. 103. Reliance General Insurance Company Limited. Registered Office: H Block, 1st Floor, Dhirubhai Ambani Knowledge City, Navi Mumbai - 400710. **Corporate Office:** Reliance Centre, South Wing, 4th Floor, Off. Western Express Highway, Santacruz (East), Mumbai - 400 055. Corporate Identity Number U66603MH2000PLC128300. Trade Logo displayed above belongs to Anil Dhirubhai Ambani Ventures Private Limited and used by Reliance General Insurance Company Limited under License. RGI/MCOM/CO/MI-01/CF/Ver. 1.5/030718.

e) Was the injured person engaged in the occupation when the accident occurred?

If not, state exactly nature of work done at that time. ☐ Yes ☐ No

f) Is the injured person in your direct employment? If so, state the date of appointment. ☐ Yes ☐ No

If not, give name and address of Contractor under whom employed and nature of work entrusted to contractor.

[copy of the last voucher obtained from the injured person for the wages paid to be attached.]

g) Under what item of the policy is the injured workman covered?

6. Details of accident

a) Premises at which accident occurred.

b) Exact occupation of the premises and general nature of work done.

c) Time and date of occurrence of accident: Date: d d m m y y y y Time: h h m m AM / PM

d) Time when reported and by whom: Time: h h m m AM / PM

e) Time and date when the injured person actually ceased work: Date: d d m m y y y y Time: h h m m AM / PM

f) Describe how the accident occurred

g) Are you satisfied that the accident occurred in the course of and arising out of employment? ☐ Yes ☐ No

h) Was the injured person under the influence of alcohol or drugs at the time of accident? ☐ Yes ☐ No

I) Was the injured person guilty of misconduct or disobedience to orders or rules? ☐ Yes ☐ No

j) State whether the accident occurred as a result of negligence on the part of any employee

k) Has the accident been reported to police or inspector of labour? ☐ Yes ☐ No

(A copy of the report to be attached)

7. Details of Loss

a) Describe nature of injury and part of body affected

b) Describe initial treatment offered. If so, When?

State whether the injured person was admitted in hospital ☐ Yes ☐ No

c) How long is the injured person expected to be in hospital?

d) What is the medical opinion on nature and extent of disablement?
(A copy of the preliminary Medical Report to be attached)

e) How long is the disablement expected to last?
(A copy of the fitness certificate from attendant doctor to be obtained after returning to work)

f) Do you any other insurance covering the workman against WC, Personal Accident, E. S. I. Scheme?
If so, give details. ☐ Yes ☐ No

9. Please give any other particulars relevant to the claim

10. Bank Details

Would you like to opt for NEFT payment? ☐ Yes ☐ No

If YES, please enclose a cancelled cheque leaf along with the claim form.

Bank Name

Branch Name

A/C Holder Name as in Bank Record

City State

Account No IFSC Code

(this is a 11 digit code printed on your cheque leaf)

Declaration by Insured

I/We hereby declare that the statements made by me / us in this claim form are true to the best of my / our knowledge and belief.

Date: d d m m y y y y

Signature of Insured/
Authorized Signatory

Place:

Statement of Wages

(A) If the injured person has been in the Employer's service during a continuous period of more than one month immediately preceding the accident, then the wages that have been paid, or fallen due for payment to him in each month of such period (not exceeding twelve preceding months in all) must be entered in the statement.

(B) If the injured person has been in the Employer's service for less than one month, the wages paid to another workmen employed on the same kind of work by the Employer, during the twelve months immediately preceding the accident, must be entered in the statement.

© If worker is daily paid employee, give

I daily rate of wages ₹

ii number of days on an average that he/she works in a month

Table of Wages

Please fill in the Table of wages below as applicable to [A],[B] or [C]

Month & Year	Basic Pay & D. A. (₹)	Overtime, Bonus and Dearness Allowance (₹)	Concession value of food-stuff (₹)	Value of free quarters (10% of basic Pay) (₹)	Total (₹)	** ABSENCE
Total						

** In column "Absence" give date of going on leave or beginning of period of absence and also of subsequent resumption of work.

Total earning in the period

from _____

to _____

Average monthly wages _____

The above statement of earnings etc. are, to the best of my knowledge and belief, accurate.

Date: [d d|m m|y y y y]

Place: _____

_____

Signature of Insured/

Authorized Signatory

[Add below any additional information available regarding the accident]

* Mandatory details to be filled

Please courier documents to the below 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.

This form shall be applicable to following policies issued by Reliance General Insurance Company Limited -Employees Compensation Insurance Policy UIN of Employees Compensation Insurance Policy. UIN No.: IRDA/NL/F&U/RGI/WC

Document Check List for Employee Compensation Claim Submission

Sr .No.	Accidental Death Claim Document Type	Yes/No
A	Duly filled and signed Claim form	
B	Attested copy of Attendance Register	
C	Attested copy of Wage Register	
D	Copy of the Intimation letter sent to WC Commissioner	
E	Original/Attested copy of Death Certificate	
F	Attested copy of Post Mortem Examination report	
G	In Case of Accident- Copy of Medico Level Certificate from hospital	
H	Copy of Photo ID proof of Insured person(Employee/Member ID card)	
I	Attested copy of FIR of local police station or Detailed Police Information note or Inquest Panchnama / Spot Panchnama (if applicable)	
J	In case of Hospitalization: Complete treatment record like Discharge summary, Consultation papers with supporting Investigation reports like X-ray/MRI etc.	
K	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.	
L	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	Attested copy of Attendance Register	
C	Attested copy of Wage Register	
D	Copy of the Intimation letter sent to WC Commissioner	
E	Detail Incidence report by the Supervisor	
F	Complete treatment record like Discharge summary, Consultation papers with supporting Investigation reports like X-ray/MRI etc.	
G	In Case of Accident- Copy of Medico Level Certificate from hospital	
H	Attested copy of FIR of local police station or Detailed Police Information note or Inquest Panchnama / Spot Panchnama (if applicable)	
I	Disability certificate issued by Senior Medical Officer mentioning the disability percentage.	
J	Coloured and clear photograph of Disabled person showing the disability	
K	Copy of Photo ID proof of Insured person (Employee/Member Photo ID proof)	
L	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.	
M	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	Attested copy of Attendance Register	
C	Attested copy of Wage Register	
D	Copy of the Intimation letter sent to WC Commissioner	
E	Detail Incidence report by the Supervisor	
F	Medical Certificate confirming the Disability period and the probable date to resume duty/service	
G	Complete treatment record like Discharge summary, Consultation papers with supporting Investigation reports like X-ray/MRI etc.	
H	In Case of Accident- Copy of Medico Level Certificate from hospital	
I	Leave Certificate from the Employer mentioning the leave dates	
J	Copy of Photo ID proof of Insured person (Employee/Member Photo ID proof)	
K	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.	
L	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.