RELIANCE General Insurance
Anil Dhirubhai Ambani Group

PERSONAL ACCIDENT INSURANCE CLAIM FORM

The issue of this form does not constitute admission of 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:	
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.				
	E-mail Id				
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: b) Time of accident: c) Place of accident: d) Name & address of the witness:	

7. Particulars of the accident:	
8. Nature of injury received (if to limb or eye state whether right or left)	

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9. a) Nature of disablement b) Extent of disablement c) Period of temporary total disablement d) Present state of incapacity	(From……to…..……)
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? b) If so state name and address of company or companies and amount of insurance	

I/We hereby declare that the foregoing statements made by me/us are true in all respects, that I/We have not attempted to conceal from the Company anything with which it ought to be made acquainted and that if I/We have made or in any further declaration the Company may require shall make any false or fraudulent statement or untrue averment whatever, the Policy shall be void and my/our right to compensation forfeited. I am/We are willing if required, to make and provide to the Company a statutory Declaration of the whole of the foregoing statement or of any other statement made in connection with this claim.

Witness: Name……
Signature ……

Signature of the Insured
Name ……..
Address …….
……..
Date:

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MEDICAL CERTIFICATE

(Claim must be supported by medical evidence furnished by the Insured at his/her expense)

1. a) Name of Claimant (b) Age

1. 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

2. Date on which you first attended claimant for this injury

3. Has claimant been totally prevented from attending to any portion of his business? If so, for how long?

4. 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

5. Present condition

6. 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: