RELIGARE Values that bind | Health Insurance

Claim Form - 'Group Secure'

To be filled by the Insured. Please fill in CAPITAL only.

Claim No.: _____

Policy Details

Policy No. :

Date of Inception : / / (DD/MM/YYYY)

Group/Company Name :

Details of the Insured Person in respect of whom claim is made

Name of Insured Member :

Name of the Insured :

Date of Birth of Insured : / / (DD/MM/YYYY)

Relationship with the Insured Member :

Gender of Insured : M F

Address :

City :

State : Pin Code :

Landline : - Mobile :

E-mail :

Primary Insured's Bank Details

Bank :

Account Number :

Branch :

PAN :

Cheque/DD No. :

IFSC/Swift Code :

Details of Hospital/Nursing Home in which treatment was taken

Name of the Hospital :

Address :

City :

State : Pin Code :

Landline : -

E-mail :

Registration No. and Rubber Stamp of the Hospital :

Date of Admission : / / (DD/MM/YYYY) Time of Admission : : (HH:MM)

Date of Discharge : / / (DD/MM/YYYY) Time of Discharge : : (HH:MM)

Details of Attending Medical Practitioner/Doctor/Treating Physician or Surgeon

Name of the Treating Doctor :

Qualification :

Registration No. :

Address :

City :

State : Pin Code :

Landline : - Mobile :

E-mail :

Claim Details

Date of Accident : / / (DD/MM/YYYY)

Time of Accident : : (HH:MM)

Place of Accident :

What were you doing at the time of Injury? _____

Name of Witness :

Address :

City :

State : Pin Code :

Landline : - Mobile :

E-mail :

Brief explanation by the witness (if any) : _____

If more than one witness, please provide additional details on a separate sheet.

Whether FIR Filed? ☐ Yes ☐ No If Yes, FIR No. : _____

Date of Admission : / / (DD/MM/YYYY) Date of Discharge : / /

Nature of Claim : ☐ Non-Fatal Injury ☐ Fatal Injury

Non-Fatal Injury

Nature of Injury :

Nature of Disablement :

Extent of Disablement : _____

(Percentage of disability as assessed by the attending doctor)

Period of Temporary Total Disablement : (No. of Days)

Total Period of Confinement : From / / (DD/MM/YYYY) To / /

(From date of accident till recovery)

Fatal Injury

Cause of Death as per attending doctor :

Post mortem - 1) Date : / / (DD/MM/YYYY)

2) Hospital :

Are the injuries referred to the sole and direct cause of your being rendered completely disabled from attending to your usual business or occupation?

☐ Yes ☐ No

If Yes, I was totally disabled : From ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) To ☐☐ / ☐☐ / ☐☐☐☐

Have you, since the accident been able to attend to your business or occupation in Part only? ☐ Yes ☐ No

If Yes, I was partially disabled : From ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) To ☐☐ / ☐☐ / ☐☐☐☐

What hours and duties are you working? ☐☐☐ Days ☐☐☐☐ Hours

During the 24 hours before the injury, did you drink any alcohol or take any drugs? ☐ Yes ☐ No

State types & quantities

Are you at present totally disabled? ☐ Yes ☐ No

If Yes, when do you consider you will be able to attend to

(I) Some of your Business or Occupation : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

(II) The whole of your Business or Occupation : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Is this injury or condition a resultant of your work environment? ☐ Yes ☐ No

If yes, how exactly did it occur? ____________________

____

Have you ever had this or a similar condition in the past? ☐ Yes ☐ No

Date(s) : ____________________

Treatment received : ____________________

____

Name of treating Doctors/Specialists : ____________________

What other significant medical or surgical treatment have you received in the past 5 years? ____________________

____

Date(s) : ____________________

Nature of the condition(s) treated : ____________________

Name of treating Doctors/Specialists : ____________________

Are you affected by any other long term or chronic disability? ☐ Yes ☐ No

Provide details : ____________________

Please provide detail of your regular Practitioner :

Name : ____________________

Address : ____________________

Contact No. : ____________________

Amount of claim (Please mention & include under what head claims are lodged viz. Medical expenses, funeral expenses, Children educational grant etc. & attach separate sheet if the space is insufficient)

S No.	Details	Bill No.	Date	Amount (₹)
1			(DD/MM/YYYY)	
2				
3				
4				
5				
6				
			Total	

Details of Other Policy

Do you have accident insurance policy with any other insurance company? If yes, please provide the following details :

Name of the Insurance Company	Policy Number	From	To	Sum Insured (₹)

Please attach additional sheet to specify any other documents appended, if required, as per the policy details

S No.	Type of Document	Tick	S No.	Type of Document	Tick
1	Duly filled and signed claim form		10	Copy of the medico-legal certificate	
2	Hospital Payment Receipt		11	Copy of Id card	
3	Pharmacy Bills		12	Copy of PAN	
4	Investigation Reports/Reports Name		13	Ambulance Bill with Payment receipt	
5	Discharge Summary		14	Policy Copy	
6	Operation theater notes		15	Employer Certificate	
7	Hospital Main Bill		16	Nominee certificate	
8	Copy of First Information Report (FIR)		17	Disability Certificate	
9	Hospital Breakup Bill				

For death cases

S No.	Type of Document	Tick	S No.	Type of Document	Tick
18	Death Certificate		20	Copy of the legal heir certificate, if the claim is for the death of the principle insured	
19	Post mortem report				

As per the policy terms and conditions, the Company reserves its right to have the Insured examined by a doctor appointed by it for verification of diagnosis.

Notes

1. If you are claiming for weekly benefits please ensure you attach evidence of your salary details by providing a certified copy and original of either : 2 x Pay Slips or an Accountant's Statement.
2. If your claim is due to the Accidental Death by Injury of an Insured Person please attach a certified copy of their Death Certificate.
3. Please attach any other information which will assist us in our consideration of your claim.
4. Where there is insufficient space on this claim form to provide a complete answer to a question, please attach your answer on a separate piece of paper and attach it to the claim form. All attachments will form part of the claim form and be subject to the Declaration below.
5. Your Insurance adviser will advise you on where to send this claim form. If you have any doubts, you may contact us on 1800-200-4488

Declaration

I hereby declare that the statements/information given/stated by me/us in this claim form is true, correct and complete.

1. No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been with held or not disclosed.
2. If I have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void & that I shall not be entitled to all/any rights to recover there under in respect of any or all claims, past, present or future.
3. The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.
4. I also consent and authorize the Religare health insurance Company limited & third party administrator to seek medical information from any hospital/medical practitioner who has at any time attended on me.

I/We hereby declare that the particulars made by the insured person in the claim from are true to the best of our knowledge and belief.

Date : __ __ / __ __ / __ __ __ __ (DD/MM/YYYY) Signature of Claimant : ____________________

Place : ____________________

Employerís Declaration

This is to certify that Mr. / Ms. ____________________

working as ____________________ Permanent employee ID No. __________

covered under Group Secure Policy No. ____________________ has been unable to attend his/her occupation

as a result of Injury from ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) to ☐☐ / ☐☐ / ☐☐☐☐

Sum Insured _____

He/she has been employed since _____

Has a claim for Worker's Compensation been lodged? ☐ Yes ☐ No

The total numbers of employees on permanent rolls as on the date of accident were _____

The above information is true to the best of my knowledge and we agree to provide any further information that may be required.

Date : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Signature of Authorized Person : _____

Place : _____ Name of Authorized Person : _____

Company Seal :

To be filled by the Attending Physician.

Name of Primary Member :

Date of Birth : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Gender :

Address :

City :

State : Pin Code :

Date when injured was brought to you first : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Diagnosis :

Is the present condition/disability attributable to congenital defect? ☐ Yes ☐ No If yes, please provide details : _____

_____

_____

Nature of the accident and details of injuries sustained : _____

_____

_____

Are the injuries solely due to the accident or traceable to any previous injuries/disease/infirmities? Provide details : _____

_____

Is the Claimant now, or had they at the time of the accident, subject to or suffering from any other injury, illness or disease? ☐ Yes ☐ No

If Yes, please provide full details: _____

Are you satisfied that the injuries were caused in the manner as stated to you and that their appearance is consistent with such statement?

☐ Yes ☐ No

If No, please state reasons : _____

Upon which Dates : (i) Did the injury occur begin : _____

(ii) Claimant become totally unable to attend to his/her usual business or occupation : ☐ Yes ☐ No

Was injured/deceased under the influence of intoxicants or drugs at the time of accident? ☐ Yes ☐ No If yes, please provide details of

diagnosis done and alcohol content : _____

How long have you been the patient's usual doctor/medical practice?_____

Was the patient referred by you or to you? _____

If Yes, please provide details of referring doctor

Doctor's Name :

Qualification :

Registration No. :

Address :

City :

State :

Pin Code :

Landline : -

Mobile :

E-mail :

Is the patient still disabled? Yes No If No, when did the patient return to work? _____

If Yes, how long will the patient be Totally disabled (unable to perform any part of their occupation)

From / / (DD/MM/YYYY) To / /

Partially disabled (able to perform part of their occupation)

From / / (DD/MM/YYYY) To / /

If partially disabled, what duties could the patient perform and for how many hours a week? _____

_____

Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, Workers Compensation insurer, Social Security, sports body or any other insurance body? Yes No

If Yes, give details : _____

Name of Company and Claim No : _____

Contact Name and Telephone No.: _____

Remarks : _____

_____

If available please provide a copy of X-Ray report

I hereby declare that the information furnished in this claim form is true and correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any relevant fact, right to claim under this claim shall be forfeited. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Doctor's Name :

Qualification :

Registration No. :

Address :

City :

State :

Pin Code :

Landline : -

Mobile :

E-mail :

Date : / / (DD/MM/YYYY)

Doctor's Seal and Signature :

Place : _____

To be completed by nominee in the event of insured's death.

Name of Primary Member :

Date of Birth : / / (DD/MM/YYYY)

Relationship with Claimant :

Gender :

Address :

City :

State : Pin Code :

Landline : - Mobile :

E-mail :

If nominee is minor, kindly provide the Legal Guardian details.

Name of Primary Member :

Date of Birth : / / (DD/MM/YYYY)

Gender :

Address :

City :

State : Pin Code :

Landline : - Mobile :

E-mail :

I/We hereby declare and warrant the truth of the foregoing particulars in every respect. I/We agree that if I/We have made or shall make false or untrue statement, suppression or concealment, my/our right to compensation shall be forfeited.

I/We also hereby declare that I am/we are accepting the amount in full discharge of your obligations under the policy to the Insured Person and/or his/her legal heirs. I/we will hold you indemnified in the event of any claim under this policy being made against you by any other person or persons.

Date : / / (DD/MM/YYYY)

Signature of Nominee/Legal Guardian : _____

Place : _____

Name of Nominee/Legal Guardian : _____