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BAJAJ Allianz

Bajaj Allianz General Insurance Co. Ltd.
Regd. & Head Office: GE Plaza, Airport Road, Yerawada, Pune 411 006
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Toll free no: 1800-209-5858
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(To be filled in block Letters)

CLAIM FORM FOR RETAIL PERSONAL ACCIDENT POLICIES

Policy No.		**Claim No.**	
Group Name			
Are insured with any other Insurance or Offices granting compensation for accident? If Yes Kindly provide us with Details of the policy			

1. Name of the Insured / Proposer	**First**	**Middle**	**Last Name**
2 Profession or Occupation.			
3. ID Card Number			
3. Name of the insured person died/injured in the accident			
4.Relationship With Employee/Member			
5 Address of the Insured :	**House No. / Building**		
	Area 1		
	Location		
	City		
	State		**Pin code**
Contact Number: **E-Mail ID:** **Aadhar Card Number:** **Pan Card Number:**	_____ _____ _____ _____		
6.Claims under Which Benefits (Tick against the benefit)	☐ **Death** ☐ **Permanent Total Disability** ☐ **Accidental Hospitalization** ☐ **Medical Expenses** ☐ **Transporation / Ambulance** ☐ **Others (Please Specify)** _____		☐ **Permanent Partial Disability** ☐ **Temporary Total Disability** ☐ **Hospital Cash** ☐ **Children Education Bonus** ☐ **Burial Expenses / Mortail Remains**
7.Date and Time of the Accident **Where did it happened / Location** **How did the Accident occur?** **Final Ailment**	_____ _____ _____ _____		
8. Whether Accident Reported to Police? **If Yes Please confirm FIR / MLC (Details)** **MLC report and Police FIR attached**	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**		
9. Is there any Accidental Hospitalization? If Yes Please confirm Date of admission and Date of Discharged	**Date of Admission DD/ MM /YYYY** **Date of Discharge DD/ MM /YYYY**		
10 .Name & Address of Hospital			
11. Name, Address and Contact details of Treating Doctor			
12. In case death of insured, please mention Date of Death			
13 .In case of Death , if beneficiary is Employee , Please provide the Nominee Details: **a)Address of Nominee** **b) Contact Details of nominee** **b) Aadhar Card Details of Nominee** **c) Pan Card Details of Nominee**	_____ _____ _____ _____		
14.Permanent Total Disability/Permanent Partial Disability/Temporary Total Disability	**Medical Certificate from Treating Doctor Mandatory as same attached in the Claim Form**		

In Support of the claim, I enclosed the below tick documents along with the claim form.

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Common Documents for Group Personal Accident.	Benefits.
• Claim form duly filled and signed by the insured / Claimant. • Beneficiary Name against the Policy and NEFT Details of Beneficiary: **Corporate / Employee** • Completely filled NEFT details stating Branch, Branch IFSC Code, Account type, Complete Account Number duly signed by Nominee / Claimant with original pre printed cancel cheque if pre-printed cheque is not available Kindly provide 1st Page of Bank Pass Book/ Bank statement Attested by the Bank which clearly indicates Beneficiary Name & Complete Account no as well IFSC code.(All Fields in the form are mandatory to process). • Aadhar Card & Pancard details of Nominee / Claimant. • In case of Unnamed Policy we will require Salary Slip at the time of issuance of the policy for Salary Commensuration. • In case of Unnamed Policy Kindly provide the attendance record/Roll from the Employer duly signed and sealed by the employer (For Confirmation of Total Number Of Employees On Roll at The Time Of Accident. **Accidental Hospitalization:** • Original Discharge Summary. • All the previous Consultation Papers • Investigation Reports supporting the diagnosis. • Operation Theatre Notes • Original Final Bill with detailed bill break up and Paid Receipts • Original Pharmacy and Investigation Bills	**Death:** • Attested copy of Death certificate • Attested copy of FIR / Panchanama / Inquest • Attested copy of Post Mortem Report • Attested copy of Viscera /Chemical analysis Report if any • Hospitalization documents, if any • **In case of Death if Nominee** is not defined on the policy copy then we will require the below documents • Legal heir certificate containing affidavit and indemnity bond on 200 INR (As per attached format).The same should be duly signed by all legal heirs, notarized. • If Nominee is minor then we will require Decree Certificate from Court stating the guardian of the insured **Permanent Partial Disability and Permanent Total Disability:** • Duly filled Medical Certificate attached in the Group Personal Accident Claim Form. • X-ray films /Investigation reports supporting the diagnosis. • Permanent Total Disability and Permanent Partial Disability Certificate from the Government authority certifying the disability of the insured. • Photograph of the patient before and after the accident to support the disability. **Temporary Total Disability :** • Duly filled Medical Certificate attached in the Group Personal Accident Claim Form • Leave certificate from employer stating the exact leave period, duly signed and sealed by the employer. • All the consultation papers with details of treatment during TTD period. • Final medical fitness certificate from treating doctor stating the type of disability, disability period and declaration that patient is fit to resume his duty on given date. • X-ray films /Investigation reports supporting the diagnosis. **Add On Cover:** **Children Education Bonus:** • In Case of Death and PTD, Kindly provide bonafide certificate from the school authorities stating that child of the insured is studying over there. (Mentioning - Name, S/D/o, Date of Birth and Class) School Identity Card. **Burial Expenses & Transportation Expenses:** • Original Paid Receipts **Hospital Cash Expenses:** • Copy of Final Bill and Discharge Summary. • Investigation reports toward diagnosis.

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT (Submission of Cancelled Blank Cheque Leaf with Payee Name Printed OR Copy of the First page of the Bank Passbook is Mandatory)

Name of the Account Holder (As per Bank Account):_____

Bank Account No (As per appearing in the cheque book): _____

Bank Name: _____

Bank Branch Address: _____

IFSC Code: _____MICR Code: _____

Account Type: ☐ Saving ☐ Current ☐Cash Credit

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize Bajaj Allianz General Insurance Company Limited, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim.

Witness:

Name: _____

Signature: _____

Signature of the HR officer of Unit / Location: _____

Date:_____

Name of Claimant / Proposer: _____

Signature of the Claimant / Proposer: _____

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MEDICAL CERTIFICATE

(Claim must be supported by the Medical Evidence furnished by the Insured at his/her expense)

1(a)	Name of Claimant	
(b)	Age / Gender	
2(a)	Type of disability	☐ Permanent Total Disability ☐ Permanent Partial Disability ☐ Temporary Total Disability
(b)	Date and Circumstances of Injury stating diagnosis and details of Injury	
(c)	Date on which you first attended claimant for this injury	
(d)	If Injury give cause	☐ Self-inflicted ☐ Assault ☐ Road Traffic Accident ☐ Substance Abuse /Alcohol Influence ☐ Others (Please Specify) _____
(e)	If Medico legal Done : If Reported to Police:	☐ Yes ☐ No ☐ Yes ☐ No
3	Extent of Disablement for Permanent Total Disability and Permanent Partial Disability as per Extraordinary Gazette Notification issued by Ministry of Social Justice & Empowerment, GOI, Part II, Sec. 1, June 13, 2001	Date Of Injury :- Disability % :-
4	Period of Temporary Total disablement (From Date of Injury to Fit to resume his Duty Date.	Date of Injury: Fit to resume his Duty Date on: No of Days:
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 State of Incapacity	☐ Fit ☐ Disable

Having personally examined the above named Insured, I certify that the above statements are correct and that the injured person is necessarily disabled by the accident referred to.

Name of the Doctor **Seal and Signature**

Qualification & Registration Number:

Address: