RELIANCE
General Insurance

Helpline 1800 3002 8282 (toll free)
022 3989 8282 (charges apply)
Claims 1800 103 1999 (toll free)
022 4111 2600 (charges apply)
www.reliancegeneral.co.in

Reliance Personal Accident Insurance Policy
Claim Form

Issuance of this form does not imply acceptance of the 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 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. 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: d d m m y y y y

b) Time of accident: h h m m AM / PM

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)

9. a) Nature of disablement

   b) Extent of disablement

   c) Period of temporary total disablement From [d d m m y y y y] To [d d m m y y y y]

   d) Present state of incapacity

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? ☐ Yes ☐ No

    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:

MEDICAL CERTIFICATE (To be filled by treating Doctor)

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

1. a) Name of Claimant (b) Age

2. 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

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

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

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 condition

7. 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: _____

_____

List of Documents Attached

SN	Description	Bill No.	Amount