RAHEJA QBE
Raheja QBE General Insurance Company Limited
5th Floor, A Wing, Fulcrum, IA Project Road, Sahar, Andheri East, Mumbai – 400059, India.
Tel: 022-69155050 I Email: customercare@rahejaqbe.com I Website: www.rahejaqbe.com
CIN: U66030MH2007PLC173129, IRDAI Reg. No. 141

CLAIM FORM – ABILITY SHIELD INSURANCE POLICY

Please answer all questions completely. If the space provided is insufficient, please use a separate sheet and attach it to this form.
The issuance of this form is not to be construed as an admission of Liability.

Policy Holder's Details

Policy No: _____ Claim No: _____

Policy Period: From_____To_____

Corporate Name: _____

Address: _____

City: _____State: _____Pin code: _____

Mobile Number: _____Email ID: _____

Phone No: _____

Claimant's Details

Name: _____

Email: _____

Address: _____

City: _____State: _____Pin code: _____

Mobile Number: _____Email ID: _____

Phone No: _____

Relationship with Insured Person: _____

Name of the Insured Person: _____

Sex: _____ Date of Birth: _____

Employee/Member Identification No: _____

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Claims under Which Benefits (Tick against the benefit)

➢ **Functional Incapacity**

- Confinement to bed ☐ Yes ☐ No

  If yes, ☐ Intermittent ☐ Bedridden

- Activities of Daily Living which insured member is unable to perform ☐ Bathing ☐ Dressing ☐ Eating ☐ Toileting ☐ Transferring ☐ Continence ☐ Hygiene ☐ Feeding ☐ Independent movement ☐ Others

Details of Disability cause due to Illness/Injury

1. Date of Illness/Injury: _____/_____/_____ Time: _____AM/PM_____

2. Place of Illness/Injury: _____

City: _____State: _____Pin code: _____

3. How did Illness/Injury occur? _____

4. If Injury, was it reported to Police? Yes _____ No_____ If yes, please give the following details.

Name and address of Police Station: _____

FIR No: _____Date: _____

Medico Legal Certificate (MLC) Report: _____

If no, please give reasons: _____

Are there any witnesses to the accident? Yes_____No_____ if yes, please provide contact details of witnesses.

Name	Address	Contact No.	E-mail ID

5. Details of Injuries/Illness Sustained_____

6. Extent of disablement: _____

7. Hospitalization/Treatment details.

   Name, Address, and contact details of Medical Practitioner consulted after the Injury/Illness:

_____

_____

_____

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8. Was the Insured Person hospitalized following the Illness/Injury? Yes No.

If yes, please provide the name, address & contact details of the hospital.

_____

_____

_____

Period of hospitalization: From _____To_____

9. Estimate of Claim Amount: _____

10. Details of any other insurance (arranged by self, spouse, parents or employee) under which claimant/deceased is covered.

Name of insurer	Policy Number	Period of Insurance	Coverage	Sum insured

I hereby warrant the truth of foregoing statement and sincerely declare that I have not suppressed or concealed any information that is material to this claim. I understand that false declarations may result in RQBE being able to refuse to pay a claim.

I authorize any hospital, physician or any other medical provider who has attended or examined me/insured person to furnish RQBE such details of medical history/treatment as they may require.

Date: _____Signature of Insured/Claimant_____

To be completed by Employer (Applicable for an Employer-Employee Policy)

This is to certify that:

Mr./Ms._____, working as_____

Employee ID No._____ covered under Ability Shield Insurance Policy Insurance Policy No _____was on leave for the period _____To_____

Mr./Mrs. is covered under the policy for a sum insured of Rs_____ The total number of employees on the rolls as on date of accident was_____

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

Signature of Authorized signatory **Date:**

Name & Designation of Authorized signatory:

Company Seal:

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Documents to be attached to the claim form:

1. The Insured / Insured Person or his / legal representative as the case may be, is required to submit the following documents while lodging a claim under the Policy. The documents mentioned below are an indicative list. Additional documents may be asked, if required, for specific claims.

i. Duly completed Claim Form signed by Insured/ Nominee
ii. Attending Physician's Statement
iii. Claimant's Statement – Please provide brief details of accident/illness and enclose with claim form.
iv. Copies of medical documents supporting the disability and treatment taken related to the same.
V. Copies of Investigation Reports and X – Ray films supporting the accidental injury. Post-Operative X-ray films, if any

2. Photocopy of Policy Schedule /Certificate of Insurance / KYC documents / Employee ID
3. In case of Employer Employee Group Policy
   i. Leave Records with seal and signature of Authorized signatory of the organization specifying the period of leave and reason for the same.
   ii. Employee ID card
5. First Information Report and Final Police report, wherever necessary.
6. Bills and receipt towards expenses relevant to funeral ceremony / repatriation of mortal remains.
7. Death certificate, wherever applicable.
8. Copy of Photo ID and Address Proof of Insured Member for whom Claim is lodged.
9. Legal Heir Certificate containing affidavit and indemnity bond both duly signed by all legal heirs and notarized (Mandatory if Nominee name is not mentioned on policy schedule/Certificate of Insurance).
10. Authorization Letter – Authorization letter has to be submitted if you are authorizing another party to handle the claim (including collection of cheque) on your behalf.
11. Consultation papers for all past and ongoing treatments.
12. NEFT/Bank Details (to enable direct credit of claim amount in bank account) and cancelled cheque.
13. KYC (Identity proof with Address – Pan card, Aadhar card, CKYC form) of the proposer.
14. Photocopy of 12 months' Salary slips/ Form 16/26/ITR as per insurer discretion confirming the loss of monthly income
15. Any other relevant documents requested during claim processing

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Medical Attendant's Certificate

1. How long have you known this patient? _____

2. Are you his/her usual Medical Attendant? Yes_____No_____

3. Name of Patient: _____

4. Occupation: _____

5. Are the injuries solely due to the accident or traceable to any previous injuries / Illness?
_____

6. Kindly state the nature of and extent of injuries/Illness
_____

7. Is the injury consistent with claimant's description of the accident? Yes _____No_____

8. Are the injuries connected with any previous injury/Illness, infirmity, or disease? Yes_____No_____
If yes, please provide details_____

9. When were you first consulted for this injury/Illness (DD/MM/YYY) _____

10. Please give details of other consultations (if any)
Doctor's Name: _____
Address: _____
Contact No: _____

11. Are you still treating the patient for the injury/Illness? Yes _____No_____

12. Kindly provide details of treatment prescribed. _____

13. If x-ray has been done, please mention the findings and Radiologist's report: _____
_____

14. If the patient was hospitalized, please give name of the hospital_____
_____

15. Period of hospitalization: (DD/MM/YYY) _____

16. Date & Nature of surgical procedure, if any (DD/MM/YYYY) _____

17. Are there any complications which may retard the recovery? Yes_____ No_____
If yes, please give details. _____

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18. Was the patient under the influence of intoxicants or drugs at the time of accident? Yes____No_____

19. While under your care and direction, how long was or will the patient be:
a. Totally unable to perform activities of daily living from (DD/MM/YYYY) _____

20. Please comment on any additional factor that may prolong recovery from injury/Illness/disability
_____

I certify that I have personally attended to the named above patient and the above statements are correct.

Signature: _____
Name: _____

Qualification: _____
Address: _____

Registration No: _____

Date: _____

Please affix official seal/stamp