

Bajaj Allianz General Insurance Co. Ltd.
Regd. & Head Office: GE Plaza, Airport Road, Yerawada, Pune 411 006
Email id: customercare@bajajallianz.co.in
Toll free no: 1800-209-5858
Land line number:-020-30305858

(To be filled in block Letters)

CLAIM FORM FOR GROUP PERSONAL ACCIDENT POLICIES

Policy No.	
Claim No.	
Corporate Name	
Address of the Unit/ Location.	

Policy issued Name or Unnamed basis Named Unnamed

Please confirm if insured with any other Insurance or Offices granting compensation for accident?

If Yes Kindly provide name of insurance company and policy number and Sum Insured _____

Insured / Proposer Details

1 Name of the Insured/ Proposer									
2 Profession or Occupation									
3 Employee Number	Employee Date of Joining <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
4 Name of the insured person died/injured in the accident									
5 Relationship With Employee/ Proposer									

6 Address of the Insured

House No.	Area
City	State
Pin code	Contact Number
E-Mail ID:	
Aadhar Card Number /UID:	PAN Card Number

7 Claims under Which Benefits (Tick against the benefit)

- Death Permanent Partial Disability Permanent Total Disability Temporary Total Disability Accidental Hospitalization Hospital Cash
 Medical Expenses Children Education Bonus Transportation / Ambulance Burial Expenses / Mortail Remains

Others (Please Specify) _____

8	Date and Time of the Accident	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
	D	D	M	M	Y	Y	Y	Y		
	Where did it happened / Location									
	Where did it happened / Location									
Final Ailment										
9	Whether Accident Reported to Police?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
	If Yes Please confirm FIR / MLC (Details) MLC report and Police FIR attached	<input type="checkbox"/> Yes <input type="checkbox"/> No								
10	Is there any Accidental Hospitalization? If Yes Please confirm Date of admission and Date of Discharged	Date of Admission <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y	
Date of Discharge <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y		
D	D	M	M	Y	Y	Y	Y			
11	Name of the Hospital									
	Address of the Hospital									

12	Name of the Treating Doctor									
	Address of the Treating Doctor									
	Contact details of the Treating Doctor									
13	In case death of insured, please mention Date of Death	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y			
14	In case of Death , if beneficiary is Employee , Please provide the Nominee Details:									
	a) Address of Nominee									
	b) Contact Details of nominee									
	c) Aadhar Card / UID Details of Nominee									
	d) PAN Card Details of Nominee									
15	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.

Common Documents for Group Personal Accident.	Benefits.
<input type="checkbox"/> Claim form duly filled and signed by the insured / Claimant. <input type="checkbox"/> Beneficiary Name against the Policy and NEFT Details of Beneficiary: Corporate / Employee <input type="checkbox"/> 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). <input type="checkbox"/> Aadhar Card & Pancard details of Nominee / Claimant. <input type="checkbox"/> In case of Unnamed Policy we will require Salary Slip at the time of issuance of the policy for Salary Commensuration. <input type="checkbox"/> 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: <input type="checkbox"/> Original Discharge Summary. <input type="checkbox"/> All the previous Consultation Papers <input type="checkbox"/> Investigation Reports supporting the diagnosis. <input type="checkbox"/> Operation Theatre Notes <input type="checkbox"/> Original Final Bill with detailed bill breakup and Paid Receipts <input type="checkbox"/> Original Pharmacy and Investigation Bills	Death: <input type="checkbox"/> Attested copy of Death certificate <input type="checkbox"/> Attested copy of FIR / Panchanama / Inquest <input type="checkbox"/> Attested copy of Post Mortem Report <input type="checkbox"/> Attested copy of Viscera / Chemical analysis Report if any <input type="checkbox"/> Hospitalization documents, if any <input type="checkbox"/> In case of Death if Nominee is not defined on the policy copy then we will require the below documents <input type="checkbox"/> 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. <input type="checkbox"/> 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: <input type="checkbox"/> Duly filled Medical Certificate attached in the Group Personal Accident Claim Form. <input type="checkbox"/> X-ray films / Investigation reports supporting the diagnosis. <input type="checkbox"/> Permanent Total Disability and Permanent Partial Disability Certificate from the Government authority certifying the disability of the insured. <input type="checkbox"/> Photograph of the patient before and after the accident to support the disability. Temporary Total Disability: <input type="checkbox"/> Duly filled Medical Certificate attached in the Group Personal Accident Claim Form <input type="checkbox"/> Leave certificate from employer stating the exact leave period, duly signed and sealed by the employer. <input type="checkbox"/> All the consultation papers with details of treatment during TTD period. <input type="checkbox"/> 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. <input type="checkbox"/> X-ray films / Investigation reports supporting the diagnosis. Add On Cover: Children Education Bonus: <input type="checkbox"/> 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: <input type="checkbox"/> Original Paid Receipts Hospital Cash Expenses: <input type="checkbox"/> Copy of Final Bill and Discharge Summary. <input type="checkbox"/> 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:

Witness Name: _____

Date: | D | D | M | M | Y | Y | Y | Y |

Signature of the Witness

Signature of the HR officer of Unit / Location

Name of Claimant / Proposer: _____

Name of Claimant / Proposer:

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	<input type="checkbox"/> Permanent Total Disability <input type="checkbox"/> Permanent Partial Disability <input type="checkbox"/> Temporary Total Disability
	Date and Circumstances of Injury stating diagnosis and details of Injury	
	Date on which you first attended claimant for this injury	
	If Injury give cause	<input type="checkbox"/> Self-inflicted <input type="checkbox"/> Assault <input type="checkbox"/> Road Traffic Accident <input type="checkbox"/> Substance Abuse /Alcohol Influence <input type="checkbox"/> Others (Please Specify) _____
	If Medico legal Done : If Reported to Police:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	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 % :-
	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
	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	
	Present State of Incapacity	<input type="checkbox"/> Fit <input type="checkbox"/> 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 _____

Qualification & Registration Number: _____

Address: _____

Seal and Signature