Bajaj Allianz General Insurance Company Limited.
Regd. & Head Office : Bajaj Allianz House, Airport Road, Yerawada, Pune 411 006 | CIN: U66010PN2000PLC015329
E-mail: bagichelp@bajajallianz.co.in | Website: www.bajajallianz.com

Caringly yours

BAJAJ | Allianz

(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 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

CKYC on Nominee / Insured can be added

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	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?	☐ Yes ☐ No
	If Yes Please confirm FIR / MLC (Details) MLC report and Police FIR attached	☐ Yes ☐ No

10	Is there any Accidental Hospitalization? If Yes Please confirm Date of admission and Date of Discharged	Date of Admission D D M M Y Y Y Y — Date of Discharge 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	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.
☐ 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 shoul 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: ☐ D Saving ☐ D Current ☐ D Cash Credit

I/We authorize Insurance Company/TPA to contact me/us through SMS/Email/WhatsApp for any update on this claim.

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.

1. For retail policies/individual customers:

   Consent/Declaration to be added in proposal and claim for CKYC no.:

   I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or National Securities Depository Limited Portal for the purpose of undertaking KYC verification.

2. For Juridical person/non-individual customer:

   Consent/Declaration to be added in proposal and claim for CKYC no.:

   I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or Goods and Service Tax Portal or Ministry Of Corporate Affairs Portal or National Securities Depository Limited portal for the purpose of undertaking KYC.

3. For Group Policies:

   Consent/Declaration to be added in claim form CKYC no.:

   I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry for the purpose of undertaking KYC

4. For Juridical person/non-individual customer and Group Policies:

   Consent/Declaration to be added in claim form CKYC no.:

   I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC

Witness:

Witness Name: _____ Date: | | | | | | | | |

_____ _____

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	☐ PermanentTotalDisability ☐ Permanent PartialDisability ☐ TemporaryTotalDisability
	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	☐ Self-inflicted ☐ Assault ☐ RoadTraffic Accident ☐ Substance Abuse /Alcohol Influence ☐ Others (Please Specify) _____
	If Medico legalDone : If Reported to Police:	☐ Yes ☐ No ☐ Yes ☐ No
	Extent ofDisablement for PermanentTotalDisability and Permanent PartialDisability as per Extraordinary Gazette Notification issued by Ministry of SocialJustice & Empowerment, GOI, Part II, Sec. 1, June 13, 2001	Date Of Injury :- Disability%:-
	Period ofTemporaryTotal disablement (FromDate of Injury to Fit to resume hisDuty Date.	Date of Injury: Fit to resume hisDutyDate on: No ofDays
	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	☐ 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 theDoctor _____

Qualification & Registration Number: _____

Address: _____

Seal and Signature