**Note: CLAIM FILE SHOULD BE SUBMITED WITHIN 10 DAYS ELSE ON LATE SUBMISSION ON CLAIM MAY BE REJECTED**

1. Claim Form
2. Doctor's Medical Certificate
3. Sign on Claim Form of Policy Holder
4. One original cancelled cheque with name printed on cheque or first page of Passbook
5. Total Claim Amount: - Rs._____
6. Photo Copy of Policies (One Year or Two Year)
7. Discharge Card / Summary
8. Fitness Certificate
9. Hospital Payment Receipt with Revenue Stamp
10. All Prescriptions attached with related bills signed & stamped by the Doctor on back
11. Lab Reports (if any)
12. Films & Report of X-ray / Sonography
13. Form "C" of Hospital Registration
14. Full set Xerox of claim file for your record
15. Copy of Aadhar Card & Pan Card with Self attested of policy holder & Patient Person
16. Last Three years Income Tax Return

Bajaj Allianz General Insurance Co. Ltd

Regd. Office: Bombay Pune Road, Akrudi, Pune 411 035 & Head Office: GESCO Plaza, Airport Road, Yerawada, Pune 411 006

# PERSONAL ACCIDENT INSURANCE

## CLAIM FORM

| | | | |
|---|---|---|---|
| Policy No | | Claim No. | |
| | | Date of registration | |
| Regional/Branch Office Code | | | |
| Broker/Agent | | Code | |

| | | | | | |
|---|---|---|---|---|---|
| 1. Name of the Insured<br>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 | |

| | |
|---|---|
| 5. a)Name of the insured person died/ injured in the accident<br>b) Relationship with the employee/ member<br>c) Employee/member identification no. | Self/Spouse/Children |
| 6. a) Date of the Accident<br>b) Time of the Accident<br>c) Where it happened?<br>d) Name & Address of the Witness | |
| 7. How did the Accident occur? | |
| 8. Nature of Injury received (if to limb or Eye state whether right or left) | |
| 9. a) Nature of disablement<br>b) Extent of disablement<br>c) Period of temporary total disablement<br>d) Present state of incapacity | (From……to……) |

| | |
|---|---|
| 10. Name and address of Surgeon in attendance | |
| 11. Where and when can a Medical Officer of our Company visit you, if necessary? | |
| 12. a) Are you insured in any other Office or Offices granting compensation for accident?<br>b) If so state name and address of company or Companies and amount of Insurance | |

I/We hereby declare that the foregoing statements are true in all respects and that I/We have not attempted to conceal from the company anything with which it ought to be made acquainted and also that if I/We have made or in any further declaration the Company may require shall make any false or fraudulent statement or any suppression, concealment or untrue averment whatever, the Policy shall be void and my/our right to compensation forfeited and am/are willing if required, to make a statutory Declaration before a Justice of the Peace of the truth of the whole of the foregoing statement or any other statement I/We may make in connection with this claim.

Witness: Name.....
Signature .....

Signature of the Insured..... Date .....

Bajaj Allianz General Insurance Co. Ltd

BAJAJ | Allianz

## 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

1. 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

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

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

4. 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

5. Present condition

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

Signature:

Name:

Qualification:

Address:

## Mandate Form for Electronic Transfer of Claim / Refund Payments

| To<br>**Bajaj Allianz General Insurance Company Ltd** | |
|---|---|

Full Name: Shri / Smt / Kum / M/s _____

(As appears in your bank account)

Full Address: _____

_____ PIN Code: _____

Contact / Mobile No: _____ Email ID: _____

| | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bank Name: | | | | | | | | | | | | | | | | | | | | | |
| Branch Name & Address: | | | | | | | | | | | | | | | | | | | | | |
| Branch IFS Code for NEFT | | | | | | | | | | | | | | | | | | | | | |
| Name of the Account Holder : (As per Bank Account) | | | | | | | | | | | | | | | | | | | | | |
| Account Type | | Savings | | | | | Current | | | | | Cash Credit | | | | | | | | | |
| Account No. (as appearing in the cheque book) | | | | | | | | | | | | | | | | | | | | | |

I/we have read the declarations / conditions mentioned below.

**MANDATORY REQUIREMENT**

Preprinted copy of cheque with cancelled remark having –Account holder name / Account no / IFS code.
If Name, Account no or IFS Code of the payee is not printed on the cheque leaf, please attached copy of first page of the bank pass book.

(Beneficiary's Signature)_____ D D M M Y Y

**DECLARATION**

- I / We hereby declare that the particulars given above are correct and complete and no blanks have been left. If the transaction is delayed or not effected at all for reason of incomplete or incorrect information I / we would not hold Bajaj Allianz General Insurance Company Limited responsible.
- I / We further undertake to refund, at any time, any excess amount whether demanded by Bajaj Allianz General Insurance Company Limited or not, which has been credited to my account [due to any reason] by Bajaj Allianz General Insurance Company Limited.
- I / We further undertake to inform Bajaj Allianz General Insurance Company Limited with an advance
  notice of 6 weeks in case of any changes in the particulars of Bank / Mandate
- After Bajaj Allianz General Insurance Company Limited issuing the Payment instruction electronically through its banker, for whatever reasons, if I/we do not get the credit to my/our account, then same shall neither constitute the default in payment of amount due to me/us, or by Bajaj Allianz General Insurance Company Limited nor constitute default of any terms and conditions of any agreement with me/us.

**I have verified the documents attached with the mandate and confirm that these documents correctly belong to the Partner ID**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

**Name of Partner ID** _____

**Employee Code**_____ **Employee Name:** _____ **Designation**_____

**Place** _____ **Date**_____ **Signature** _____