To be filled by the Insured. Please fill in CAPITAL only.

Claim No.:

Policy Details

Policy No. :

Date of Inception :

/

/

(DD/MM/YYYY)

Group/Company Name :

Details of the Insured Person in respect of whom claim is made

Name of Insured Member :

Name of the Insured :

Date of Birth of Insured :

/

/

(DD/MM/YYYY)

Relationship with the Insured Member :

Gender of Insured :

M ☐ F ☐

Address

Address :

City :

State :

Pin Code :

Landline :

-

Mobile :

Email :

Primary Insured's Bank Details

Bank :

Account Number :

Branch :

PAN :

Cheque/DD No. :

IFSC/Swift Code :

Details of Hospital/Nursing Home in which treatment was taken (if any)

Name of the Hospital :

Address

Address :

City :

State :

Pin Code :

Landline :

-

Mobile :

Email :

Date of Admission :

/

/

(DD/MM/YYYY)
Time of Admission :

:

(HH:MM)
Date of Discharge :

/

/

(DD/MM/YYYY)
Time of Discharge :

:

(HH:MM)

Care Health Insurance Limited (Formerly known as Religare Health Insurance Company Limited)

Registered Office: 5th Floor, 19 Chawla House,Nehru Place,New Delhi-110019 Corresp. Office: Unit No. 604 - 607, 6th Floor, Tower C, Unitech Cyber Park, Sector-39, Gurugram -122001 (Haryana)

Website: www.careinsurance.com E-mail: customerfirst@careinsurance.com Call us: 1800-102-4488 | 1800-102-6655

Claim Details

Date of Accident :

/

/

(DD/MM/YYYY)
Time of Accident :

:

(HH:MM)
Place of Accident :
What were you doing at the time of Injury?
Name of Witness :
Address :
City :
State :
Pin Code :
Landline :
-
Mobile :
Email :
Brief explanation by the witness (if any) :

If more than one witness, please provide additional details on a separate sheet.

Whether FIR Filed?

☐

Yes

☐

No

If Yes, FIR No. :
Date of Admission :
/
/
(DD/MM/YYYY)
Date of Discharge :
/
/
(DD/MM/YYYY)
Nature of Claim :
☐ Non-Fatal Injury ☐ Fatal Injury

Non-Fatal Injury

Nature of Injury :

Nature of Disablement :

Extent of Disablement :

(Percentage of disability as assessed by the attending doctor)

Period of Temporary Total Disablement :

(No. of Days)

Total Period of Confinement : From
From:
/
/
(DD/MM/YYYY)
To :
/
/
(DD/MM/YYYY)

(From date of accident till recovery)

Fatal Injury

Cause of Death as per attending doctor :

Post mortem -

1) Date

:
/
/

(DD/MM/YYYY)

2) Hospital

:

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CIN: U66000DL2007PLC161503 UIN: IRDA/NL-HLT/RHI/P-P/V.I/255/13-14

IRDA Registration No. - 148

Are the injuries referred to the sole and direct cause of your being rendered completely disabled from attending to your usual business or occupation?

☐ Yes ☐ No
If Yes, I was totally disabled : From

From

/

/

(DD/MM/YYYY)

To

/

/

Have you, since the accident been able to attend to your business or occupation in Part only?

☐ Yes ☐ No
If Yes, I was partially disabled : From

From

/

/

(DD/MM/YYYY)

To

/

/

What hours and duties are you working?

Days
Hours

During the 24 hours before the injury, did you drink any alcohol or take any drugs?

☐ Yes ☐ No

State types & quantities

Are you at present totally disabled?

☐ Yes ☐ No

If Yes, when do you consider you will be able to attend to

(I) Some of your Business or Occupation :

/

/

(DD/MM/YYYY)

(II) The whole of your Business or Occupation :

/

/

(DD/MM/YYYY)

Is this injury or condition a resultant of your work environment?

☐ Yes ☐ No

If yes, how exactly did it occur?

Have you ever had this or a similar condition in the past?

☐ Yes ☐ No

Date(s) :

Treatment received :

Name of treating Doctors/Specialists :

What other significant medical or surgical treatment have you received in the past 5 years?

Date(s) :

Nature of the condition(s) treated :

Name of treating Doctors/Specialists :

Are you affected by any other long term or chronic disability?

☐ Yes ☐ No

Provide details :

Please provide detail of your regular Practitioner :

Name :

Address :

Contact No. :

Amount of claim (Please mention & include under what head claims are lodged viz. Medical expenses, funeral expenses, Children educational grant etc. & attach separate sheet if the space is insufficient)

SNo.	Details	Bill No.	Date	Amount (₹)
1			(DD/MM/YYYY)	
2				
3				
4				
5				
6				
			Total	

Declaration

I hereby declare that the statements/information given/stated by me/us in this claim form is true, correct and complete

1. No material information which isrelevant to the processing of the claim or which in any manner has abearing on the claim has been with held or not disclosed.
2. If I have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void & that I shall not be entitled toall/anyrights to recover there under inrespect of any or all claims,past, present or future.
3. The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reservesthe right to process or rejector requirefurther/additional information in respect of the claim.
4. I also consent and authorize the Care health insurance limited (Formerly known as Religare Health Insurance Company Limited) & third party administrator to seek medical information from any hospital/medical practitioner who has at any time attended on me.

I/We hereby declare thatthe particulars made by the insured person in the claimfrom are true to the best of our knowledge and belief.

Date :
/
/

(DD/MM/YYYY)

Signature of Claimant

:
Place :

Employer’s Declaration

This is to certify that Mr. / Ms.
working as
Permanent employee ID No.
covered under Group Secure Policy No.
has been unable to attend his/her occupation

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CIN: U66000DL2007PLC161503 UIN: IRDA/NL-HLT/RHI/P-P/V.I/255/13-14

IRDA Registration No. - 148

To be completed by nominee in the event of insured's death.

Name of Primary Member :
Date of Birth :
/
/

(DD/MM/YYYY)

Relationship with Claimant :

Gender :

Address :

City :

State :

Pin Code :

Landline :

-

Mobile :

Email :

If nominee is minor, kindly provide the Legal Guardian details.

Name of Primary Member :

Date of Birth :

/

/

(DD/MM/YYYY)

Gender :

Address :

City :

State :

Pin Code :

Landline :

-

Mobile :

Email :

I/We hereby declare and warrant the truth of the foregoing particulars in every respect. I/We agree that if I/We have made or shall make false or untrue statement, suppression or concealment, my/our right tocompensation shall be forfeited.

I/We also hereby declare that I am/we are accepting the amount in full discharge of your obligations under the policy to the Insured Person and/or his/her legal heirs.

I/we will hold you indemnified in the event of anyclaim under this policy being made against you by anyother person or persons.

Date :

/

/

(DD/MM/YYYY)

Signature of Nominee/Legal Guardian

:

Place :

Name of Nominee/Legal Guardian :

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