RELIANCE GENERAL INSURANCE
A RELIANCE CAPITAL COMPANY

reliancegeneral.co.in
(Toll Free) 1800 3009
(022) 4890 3009(Paid)

Reliance Inland Travel Care Policy
Claim Form For Group Travel Insurance

Claim No.

IMPORTANT: Please intimate claim on RGICL Call Centre at 24*7 helpline/Toll Free number.

*Policy No./Certificate No. 325478961

Period From _____ To _____

Flight No. _____ PNR No. _____

Details of Insured

*Name: ☐ Mr. ☐ Mrs. ☐ Ms. Badma

*Address:

Flat/Building _____ Road/Street/Sector _____

Area _____ City _____

*Pin Code _____ State _____ Country _____

*Phone 9658745632 *Mobile _____

*Email badma@gmail.com Aadhaar (UIDAI) No. _____

PAN No. _____

Profession/Occupation ☐ Business ☐ Profession ☐ Salary ☐ Agricultural Income ☐ Savings ☐ Others

Monthly Income ☐ Upto ₹ 20,000 ☐ ₹ 20,001 to ₹ 50,000 ☐ ₹ 50,001 to ₹ 1,00,000 ☐ ₹ 1,00,001 and above

Policyholder Bank Details

Name of the Bank Account Holder ☐ Mr. ☐ Mrs. ☐ Ms. F I R S T M I D D L E L A S T

Bank Account No.: _____ Account: ☐ Saving ☐ Current

Name of the Bank _____

Branch _____

MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank) _____

IFSC Code (11 character code appearing on your cheque leaf) _____

☐ I understand that any refund due on the premium payment / any payment / claims to be directly credited to my aforesaid Bank Account.*

*As per IRDAI, its mandatory that all payments made to the insured are only through electronic mode.

Note: Please attach original cancelled cheque and a copy of PAN card for verification of the particulars provided in this regard.

Please indicate whether claim is in respect of:

- ☐ Accidental Death and Permanent Disablement
- ☐ Compassionate visit due to Hospitalisation
- ☐ Death of Insured Person
- ☐ Travel Delay
- ☐ Trip Cancellation & Interruption
- ☐ Catastrophe
- ☐ Personal Liability
- ☐ Emergency Medical Expense due to Accident
- ☐ Emergency Dental
- ☐ Financial Emergency Assistance
- ☐ Missed Connection
- ☐ Total Loss of checked-in Baggage
- ☐ Hijack Distress Allowance
- ☐ Liability arising due to loss of credit card

1. Failure to intimate claim on the RGICL Call Centre at 24*7 helpline/Toll Free number shall invalidate your claim.
2. Issuance of the form is not an admission of liability or a waiver of terms, conditions & exceptions of the insurance contract.
3. This is a Mandatory form to be filled for all claims under any section. Please answer all questions completely. In case of insufficient space, please attach an additional sheet.
4. No claim under Accident & Sickness Section will be admitted without Doctor's Report as per format (Attending Doctor's Report).
5. Please attach all bills, receipts, credit card slips pertaining to your claim.
6. Please return the form completed within Fourteen days of the loss together with the relevant vouchers, documents, etc.

An ISO 9001:2015 Certified Company

RCare Health: Reliance General Insurance, No.1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad 500081.

IRDAI Registration No. 103. Reliance General Insurance Company Limited. Registered & Corporate Office: Reliance Centre, South Wing, 4th Floor, Santacruz (East), Off Western Express Highway, Mumbai 400055. Corporate Identity Number U66603MH2000PLC128300. UIN: RELTIDP07001V010607. Trade Logo displayed above belongs to Anil Dhirubhai Ambani Ventures Private Limited and used by Reliance General Insurance Company Limited under License. RGI/MCOM/CO/EG-04/CF/Ver. 1.4/040620

Fill the relevant sections and strike out the others.

Benefit – Accidental Death & Permanent Disability, Emergency Medical Expenses, Compassionate visit by the family member, Emergency Dental

A. DETAILS OF ACCIDENT:

a. When did the accident happen? Date d d m m y y y y Time _____ A.M./P.M.

b. Location _____

c. Full description of the accident, how, where it took place _____

_____

d. Nature and extent of loss _____

_____

e. Have the Police Authorities been informed of this accident? _____

f. If Yes, FIR No. _____ Date d d m m y y y y Name of Police Station _____

B. WITNESS:

a. Name: ☐ Mr. ☐ Mrs. ☐ Ms. _____

Address:

Flat/Building _____ Road/Street/Sector _____

Area _____ City _____

Pin Code _____ State _____ Country _____

Phone _____ Mobile _____

b. Name: ☐ Mr. ☐ Mrs. ☐ Ms. _____

Address:

Flat/Building _____ Road/Street/Sector _____

Area _____ City _____

Pin Code _____ State _____ Country _____

Phone _____ Mobile _____

C. TREATMENT DETAILS:

a. Names of the Hospital clinic or Nursing Home where the insured was treated after the accident

_____

Address _____

_____

Contact details:

Email _____

Fax _____ Telephone _____

b. The Physician/ Surgeon who attended on the insured/insured person after the Accident

_____

Contact details:

Email _____

Fax _____ Telephone _____

ATTENDING PHYSICIAN'S STATEMENT (To be filled up by the attending doctor)

1. Name of Injured Person ☐ Mr. ☐ Mrs. ☐ Ms. _____

Age _____

Date of accident d d m m y y y y

3. Describe the nature of injury sustained by the insured

4. Does the Cause of Accident as stated by the Claimant tally with the Injuries noticed by you?

5. Was he under the influence of intoxicants or drugs at the time of accident?

6. Are the injuries solely due to the accident or traceable to any previous injuries/disease/infirmities?

7. Was the Claimant hospitalized? If so, for what period? From _____ To _____

8. Details of treatment given and Operations performed?

9. In case of disability due to accident, Extent of Disability: _____ %. Whether the disability is recoverable?

10. Has this accident been reported to the Police Authorities? If yes,

a. Case No | Police Station

Doctor's Full name and Signature

Regn No.

Doctor's Contact No.

Date d d m m y y y y

Place

In case of Personal Accident Claim (Benefit 1) Amount claimed: ₹ _____

On account of: ☐ Death ☐ Permanent Total Disablement ☐ Permanent Partial Disablement

In case of Emergency Medical Expenses (Benefit 2) – Amount claimed

Sr. No.	Details of Expenses/Invoice wise	Date	Invoice amount
A	Transportation/medical evacuation of the Insured		
B	Extra costs for an accompanying person when it is medically necessary		
C	The costs of transporting the mortal remains (in case of death)		
D	Any other expense covered, claimed under this section		
		Total	

**Please attach all the corresponding original tickets/bills/invoices/receipts for claiming the above expenses.

In case of Compassionate visit by the family member (Benefit 8) – Amount claimed

Sr. No.	Details of Expenses/Invoice wise	Date	Invoice amount

Benefit - Total Loss Of Checked In Baggage

1. Date of Loss d d m m y y y y Time | Place of Loss

2. Details of item lost

Sr. No.	Description of item lost	Date of purchase	Amount of loss (₹)	Compensation received from carriers. (₹)

Note: Please attach separate sheet if the above space is insufficient.

Benefit – Trip Delay/Cancellation/Interruption

1. Reason for Trip Delay/Cancellation/Interruption:

   ☐ Death ☐ Illness/Injury

   ☐ Fire/Flood/Vandalism/Burglary/Natural Disaster

   ☐ Abduction

   a. If the loss is arising due to illness/death of family member, please specify the following:

   b. Name of the Person Affected ☐ Mr. ☐ Mrs. ☐ Ms. _____

   c. Relationship with the insured person _____

   d. Details of ailment _____

   _____

2. Schedule date of arrival d d m m y y y y
   Schedule time of arrival _____

3. Actual date of arrival d d m m y y y y
   Actual time of arrival _____

4. No. of hours delayed _____

5. Date: d d m m y y y y Time _____ Location _____ (Trip Cancellation/Interrupation)

6. Whether accommodation and boarding provided by carrier? Yes ☐ No ☐

7. Details of expenses incurred:

Sr. No.	Details of expenses incurred	Date	Place	Cost
			Total	
			Less compensation received from airlines	
			Net amount	

Benefit – Hijack Distress Allowance

1. Place of Hijack _____ Date d d m m y y y y Time _____

2. Place of Release _____ Date d d m m y y y y Time _____

3. Please provide the necessary details of the incident

   _____

   _____

   _____

   _____

Benefit – Personal Liability

Date of Loss d d m m y y y y Place of Loss _____

Please provide details of injury / property damaged

_____

_____

_____

_____

Name of aggrieved Third Party

_____

_____

Amount of Liability _____

Benefit – Catastrophe

Reason for Evacuation

Please detail out the above reason for Evacuation (how, where, when and reason for the same)

Evacuation date d d m m y y y y

Original Travel Dates From To

Time

Details of Losses/Expenses Incurred:

Sr. No.	Loss/Expenses Details	Amount
		Total

Benefit – Financial Emergency Assistance

Date of Loss d d m m y y y y

Reason and circumstances of Loss

Items lost and value of the same

I hereby declare that the above reason was the sole reason for the of my loss of travel funds. I also declare that there are no other sources of funds available to me and the financial assistance required by me are needed on an urgent basis to prosecute the remainder of my trip. I have made all efforts to recover my money unsuccessfully.

Signed (Claimant or Authorized Person)

Relationship with the Insured

Benefit – Missed Connection

Original Travel Schedule: (Please give date and time of all flights, mentioning the original and actual arrival and departure times. Please also mention the name of carriers and flight numbers)

Which flight was delayed causing a missed connection?

Reason for delay of the flight

Details of expenses due to Missed Connection

Sr. No.	Expenses	Amount
		Total

Benefit – Liability Arising Due To Loss Of Credit Card ?

Date of Loss | d | d | m | m | y | y | y | y |

Reason and circumstances of Loss

Card Details and Credit Limit

Aadhaar based payment (For Reimbursement claims)

Aadhaar Card No.: (Note: **Self attested** Aadhaar card copy to be submitted)

☐ I wish to collect claim reimbursement directly in my Bank account linked with my aforementioned Aadhaar Card. I understand that the claim amount shall be credited directly in my latest Bank account linked with my Aadhaar Card.

I/We hereby declare that the details given above are true and correct to the best of my belief and knowledge. In the event above information or any part thereof is found incorrect, I agree that all right under the policy will be forefeited.I agree to provide additional information to the Company if required. I will indemnify and hold harmless the Company due to any loss arising out of misstatement in this form and am 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 may make in connection with this claim.

I further agree and undertake not to receive from Reliance General Insurance Company Limited any rebate other than that mentioned in the published prospectus in accordance with the provisions Section 41 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015.

Place: _____

Date: | d | d | m | m | y | y | y | y |

_____

(Signature of Insured Person/Claimant)

* Mandatory details to be filled

Please courier documents to the below address:

Rcare Health: Reliance General Insurance, No.1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad 500081. Email: rgicl.rcarehealth@relianceada.com.

This form shall be applicable to following policies issued by Reliance General Insurance Company Limited - Reliance Inland Travel Care Policy UIN of Reliance Inland Travel Care Policy UIN No. :RELTIDP07001V010607