

General Insurance

**Reliance Travel Care Insurance Policy
Claim Form B**

Personal Accident/Accidental Death & Dismemberment-Common Carrier

1. Details of Accident

When did the accident happen? [] am/pm

Date of death [] Time of death [] am/pm

Location []

Please provide the necessary details about the accident _____

Please state the nature and extent of loss _____

Please state the amount claimed _____

2. Details of Witnesses

Witness 1

Name Mr. Mrs. []

Address for communication
Flat/Building/Door/Block No. []

Road/Street/Sector []

Area []

Taluka/Village/District/City [] Pin Code []

State [] Country []

Telephone No. [] Mob. No. []

Email ID [] Fax []

Witness 2

Name Mr. Mrs. []

Address for communication
Flat/Building/Door/Block No. []

Road/Street/Sector []

Area []

Taluka/Village/District/City [] Pin Code []

State [] Country []

Telephone No. [] Mob. No. []

Email ID [] Fax []

3. Treatment Details

Please specify whether the Insured Person was hospitalised for the treatment of injury due to the accident? Yes No

If yes, period of Hospitalisation From [] To []

Please provide name of the Hospital/Nursing home where the Insured Person was treated for the injury sustained due to the accident?

[]

Address for communication
Flat/Building/Door/Block No. _____

Road/Street/Sector _____

Area _____

Taluka/Village/District/City _____ Pin Code _____

State _____ Country _____

Telephone No. _____ Fax _____

Please provide the name of Physician/Surgeon who attended the Insured Person during the treatment for the injury sustained due to the accident?

Address for communication
Flat/Building/Door/Block No. _____

Road/Street/Sector _____

Area _____

Taluka/Village/District/City _____ Pin Code _____

State _____ Country _____

Telephone No. _____ Mob. No. _____

Email ID _____ Fax _____

Have the Police Authorities been informed about this accident?

Have the following documents, been submitted?

- a. Copy of FIR Yes No b. Death Certificate Yes No
- c. Police Report Yes No d. Post Mortem Report (in case of accident death) Yes No

4. **Attending Doctor/Physician's Statement** (To be filled up the by Attending Doctor/Physician)

Name of Insured Person _____

Age _____ yrs

Address
Flat/Building/Door/Block No. _____

Road/Street/Sector _____

Area _____

Taluka/Village/District/City _____ Pin Code _____

State _____ Country _____

Phone _____ Mobile _____

Email _____ Fax _____

Please state nature of the accident and details of injuries sustained

Does the cause of accident as stated by the Insured Person tally with the injuries noticed by you?

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

Was the Insured Person suffering from any disease/injury which may have contributed to the accident or likely to aggravate his/her condition.

Was the Insured Person hospitalized? If so for what period? From | | To | |

Please provide the details of treatment given and operations performed, if any? _____

Was he/she under the influence of intoxicants or drugs at the time of accident? _____

Has this accident been reported to the police authorities? If yes _____

Case No. Police Station

Name of Attending Doctor/Physician Dr.

Address

Flat/Building/Door/Block No.

Road/Street/Sector

Area

Taluka/Village/District/City Pin Code

State Country

Telephone No. Mobile

Fax Email ID

Date

Attending Doctor/Physician's Signature

Regn. No.

Contact Reliance General Insurance Company Limited : +91-22-67347843* / +91-22-67347844*

RCare ID: reliance@europ-assistance.in

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