RELIANCE GENERAL INSURANCE
A RELIANCE CAPITAL COMPANY

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

CLAIM FORM FOR COVID-19 PROTECTION INSURANCE

TO BE FILLED IN BY THE INSURED

The issue of this Form is not to be taken as an admission of liability

DETAILS OF INSURED					
a) Policy Name / No.:			b) Sl. No./Certificate No.:		
c) Insured Name:			d) Gender: Male Female		
e) Age: Years / Months	YY/MM		f) Date of birth:	(DD/MM/YYYY)	
g) Insured Address:					
City:		State:		Pin Code:	
Phone Number:			Email ID:		

Diagnosis Cover Yes/ No		Quarantine Cover Yes / No	
DETAILS OF HOSPITALISATION			
a) Name of Hospital and address where admitted:			
b) Date of Admission:	(DD/MM/YYYY)	c) Time:	HH:MM
d) Date of Discharge:	(DD/MM/YYYY)	e) Time	HH:MM

Loss of Pay* Yes / No		Loss Of Employment* Yes/No (*If Applicable)	
DETAILS OF HOSPITALISATION			
a) Name of Hospital and address where admitted:			
b) Date of Admission:	(DD/MM/YYYY)	c) Time:	HH:MM
d) Date of Discharge:	(DD/MM/YYYY)	e) Time	HH:MM
f) No.Of Days of leave due to Loss of pay : 0 – 30 days		g) Unemployment no.of Months : 1 / 2 / 3 Months	

Document Check List				
Diagnosis Cover	**Quarantine Cover**		**Loss of Pay (If Applicable)**	**Loss of Employment (If Applicable)**
ii) Claim form duly signed	ii Claim form duly signed		ii) Claim form duly signed	ii) Claim form duly signed
iii) COVID – 19 Report	iii) Hospital Discharge Summary		iii) Company LOP Certificate	iii) Termination Certificate
	iii) Final Bill		iii) Salary slip	
**	Travel Exclusion Cover	(Yes/No)	If Yes	Provide Passport / Visa copy of the claimant
**	In Case of Death (Legal Heir certificate)	(Yes/No)		

DETAILS OF CLAIMANT BANK ACCOUNT			
a) PAN:		b) Account Number:	
c) Bank Name and Branch:			
d) Cheque/DD payable details:		e) IFSC Code:	

DECLARATION BY THE INSURED

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 TPA / insurance company, 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 & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date: (DD/MM/YYYY) Place :	Signature of the Insured:

An ISO 9001:2015 Certified Company

Reliance General Insurance Company Limited. IRDAI Registration No. 103.
Registered & Corporate Office: Reliance Centre, South Wing, 4th Floor, Santacruz (East),Off. Western Express Highway, Mumbai 400055.
Corporate Identity No.U66603MH2000PLC128300. UIN – RELHLGP20152V011920. RGI/MCOM/CO/COVID-19_PROTECTION_INSURANCE-CLAIM_FORM/Ver. 1.0/100420.