



**Reliance Home LoanProtect Policy
Claim Form**

Claim No.

*Policy No.
Period From Period To
*Customer ID Date of Registration
Area Office/Service Centre Code
Broker/Agent Name Code

Details of Insured (To be filled in BLOCK LETTERS)

1. *Insured's Name Mr. Mrs.
2. *Address
Flat/Building/Door/Block No.
Road/Street/Sector
Nearest Landmark
Area
City *Pin Code
State Country
*Phone *Mobile
*Email PAN No.
*Aadhaar (UIDAI) No.
3. Date of Birth 4. Gender Male Female
5. Monthly Income Upto ₹ 20,000 ₹ 20,001 to ₹ 50,000 ₹ 50,001 to ₹ 1,00,000 ₹ 1,00,001 and above
6. Profession/Occupation Business Profession Salary Agricultural Income Savings Others
7. Loan A/C No.
8. Do you have any other Insurance
If so state name & address of company or companies & amount insured

9. Claim pertains to Personal Accident Critical Illness Loss of employment Child Care allowance
 Home Cover Home Contents

Details of the Insured/Claimant

1. NEFT details of the Insured/Claimant
2. Name of the Claimant 3. Mobile
4. Customer Name
(As per Bank records)
5. Bank Account No.: 6. Account: Saving Current
7. Name of the Bank
8. Address of Bank
Branch 9. PAN No.
10. MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)
11. IFSC Code (11 character code appearing on your cheque leaf)

I Wish: 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

Section (A) Personal Accident

1.	Date of loss/injury	<input type="text" value="d d m m y y y y"/>	Time of Accident	<input type="text" value="h h m m"/> AM/PM
2.	Place of loss/injury	<input type="text"/>		
3.	Particulars of loss/injury	<input type="text"/>		
4.	Reason for injury	<input type="text"/>		
		<input type="text"/>		
5.	Nature of injury received (if to eye or limbs, please state left or right?)	<input type="text"/>		
		<input type="text"/>		
6.	Nature of disablement	<input type="text"/>		
		<input type="text"/>		
7.	Present state of disability	<input type="text"/>		
8.	Names & Addresses of treating physicians & hospitals	<input type="text"/>		
		<input type="text"/>		
	City	<input type="text"/>	Pin Code	<input type="text"/>
	State	<input type="text"/>	Country	<input type="text"/>
	Phone	<input type="text"/>		

Section (B) Critical Illness

1.	Nature of disease/illness contracted, injury sustained or surgery performed?	<input type="text"/>		
		<input type="text"/>		
2.	Is the disease/illness contracted or surgery performed due to any accident? If YES, please provide the details of accident	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
		<input type="text"/>		
		<input type="text"/>		
3.	Date on which you first visited a doctor with complaints related to this illness/injury	<input type="text" value="d d m m y y y y"/>		
	Dr. Name	<input type="text"/>		
	Hospital Name	<input type="text"/>		
	Hospitalization Details	<input type="text"/>		
	Date of admission	<input type="text" value="d d m m y y y y"/>	Date of discharge	<input type="text" value="d d m m y y y y"/>
4.	Have you ever been hospitalized before?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Date of admission	<input type="text" value="d d m m y y y y"/>	Date of discharge	<input type="text" value="d d m m y y y y"/>
5.	Have any of your blood relatives suffered from similar or related illness? If YES, give details of when it was initially diagnosed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
		<input type="text"/>		
		<input type="text"/>		

Section (C) Loss of employment

1.	Name of the employer	<input type="text"/>		
2.	Address	<input type="text"/>		
	.	<input type="text"/>	HR Contact details	<input type="text"/>
3.	Designation	<input type="text"/>	4. Department	<input type="text"/>
5.	Date of joining the organization	<input type="text" value="d d m m y y y y"/>	6. Date of Separation	<input type="text" value="d d m m y y y y"/>
7.	Reason for separation	<input type="text"/>		

Section (D) Child Allowance

Details of Child 1

1.	Name	<input type="text"/>		
2.	Date of Birth	<input type="text" value="d d m m y y y y"/>	Birth Mark	<input type="text"/>
	Designation	<input type="text"/>	Department	<input type="text"/>
	Date of joining the organization	<input type="text" value="d d m m y y y y"/>	Date of Separation	<input type="text" value="d d m m y y y y"/>
3.	Reason for separation	<input type="text"/>		

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 forfeited. 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 Home LoanProtect Policy
UIN of Reliance Home LoanProtect Policy UIN: RELPAIP08004V010708