RELIANCE GENERAL INSURANCE

Tech+ ♥ = Live Smart

RELIANCE HEALTH GLOBAL - CLAIM FORM

DETAILS OF INSURED (To be filled in BLOCK LETTERS)			
1. Name of the Insured	☐ Mr. ☐ Mrs. ☐ Ms. F I R S T M I D D L E L A S T		
2. Address for Communication			
Flat/Building/Door/Block No.		Road/Street/Sector	
Area		Taluka/Village/District/City	
Pin Code		State	
Country		Phone	
Mobile		Overseas contact no if any	
Email		Fax	
3. Relationship of the Patient/ Insured Person with the Insured	☐ Self ☐ Spouse ☐ Son ☐ Daughter		
4. Source of fund	☐ Business ☐ Profession ☐ Salary ☐ Agricultural Income ☐ Savings ☐ Others		
5. Monthly Income:	☐ Upto ₹ 20,000 ☐ ₹ 20,001 to ₹ 50,000 ☐ ₹ 50,001 to ₹ 1,00,000 ☐ ₹ 1,00,001 and above		
6. PAN No.			
7. Does Insured have any other insurance coverage out of India?	☐ Yes ☐ No (If yes, please provide the details)		
Name of the Insurance Company			
Policy No.		Sum Insured ₹	
Policy Start Date	D D / M M / Y Y Y Y	Policy End Date	D D / M M / Y Y Y Y
Name of the Insured			

DETAILS OF PATIENT/INSURED PERSON (To be filled in BLOCK LETTERS)			
8. Name of the Patient/Insured Person	☐ Mr. ☐ Mrs. ☐ Ms. F I R S T M I D D L E L A S T		
9. Date of Birth	D D / M M / Y Y Y Y	10. Sex:	☐ M ☐ F
11. Address for Communication			
Flat/Building/Door/Block No.		Road/Street/Sector	
Area		Taluka/Village/District/City	
Pin Code		State	
Country		Phone	
Mobile		Overseas contact no if any	
Email		Fax	
12. ABHA Number			
13. ABHA Address			

Reliance Health Global. UIN No.: IRDAN103RP0001V01202324. RGI/MCOM/CO/RHG-CF/VER.1.0/301123

CLAIM DETAILS	
14. Type of Claim	☐ Global Cover Claim Expenses ☐ India Cover Claim Expenses
15. Has he Emergency Assistance Service Provider been intimated?	☐ Yes ☐ No
If Yes, please provide the reference number	
16. Passport No.	

SELECT THE APPROPRIATE COVER WHICH IS BEING CLAIMED:

17. **For Global Claim**

☐ Specified Illness ☐ In-Patient Treatment Including ambulance and organ donor expenses ☐ Pre and Post-Operative Day Care Treatment ☐ Pre and post hospitalsation ☐ Rehabilitation (Accident Only) ☐ Travel Expenses ☐ Accommodation Expenses	☐ Repatriation of Mortal Remains ☐ Second Opinion ☐ Assistance Services: Translation services | Transmission of urgent messages | Lost passport assistance | Consular Referral | Arrangement of Radio Taxi or Chauffer services | Emergency cash assistance ☐ Visa Charges and Documentation

For Indian Claim

☐ Specified Illnesses ☐ In-Patient Treatment (incl. Consumables) ☐ Day Care Treatment (incl. Consumables) ☐ Domestic Road Ambulance ☐ Air Ambulance ☐ Domiciliary Hospitalization ☐ Modern Treatment ☐ Pre and post hospitalsation ☐ Organ Donor Expenses ☐ Rehabilitation ☐ Home Care Treatment ☐ Medical Equipment ☐ OPD: Generalist consultation, specialist consultation, prescribed diagnostic test and pharmacy | Physiotherapy Benefit | Alternate/Complementary Treatment Expenses	☐ Dental Cover ☐ Health Check-Up ☐ Second Opinion ☐ No Claim Bonus ☐ Inflation Protection ☐ Unlimited Reinstatement ☐ Assistance Services: Tele-consultation | Booking of health checkups | Arrangement of Nurse at home | Emergency helpline ☐ Optional Cover ☐ Waiver of Co-Payment ☐ Voluntary Co-payment ☐ Change in Pre-Existing Waiting Period

IN CASE OF ILLNESS/IN-PATIENT TREATMENT			
Name of Treating Physician/ Doctor:			
Name of the Hospital:			
Hospital Address:			
Registration Number:		Contact Number:	

IMPORTANT GUIDELINES:

Issuance of the form is not an admission of liability or a waiver of terms, conditions & exceptions of the insurance contract.

1. Please answer all questions completely. In case of insufficient space, please attach an additional sheet.
2. Please attach all bills, receipts, payment card slips pertaining to your claim.
3. No claim under Accident & Sickness Section will be admitted without Doctor's Report as per format.
4. Failure to call our Emergency Assistance Service Provider shall invalidate your claim.

CLAIMANT'S BANK DETAILS			
18. Name of the Bank Account Holder	☐ Mr. ☐ Mrs. ☐ Ms. F I R S T M I D D L E L A S T		
19. Bank Account No.:		20. Account:	☐ Saving ☐ Current
21. Name of the Bank			
22. Branch		23. PAN No.	
24. MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)			
25. 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.

DECLARATION

I, hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited, I further declare that, in respect of the above statement, no benefits are admissible under any other Medical scheme or Insurance.

I hereby authorize any hospital, physician, or other person who has attended or examined me, to furnish to the company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records, a photostat copy of this authorization shall be considered as effective and valid as the original.

Date: _____ _____

Place: _____ Signature of Insured Person

CONTACT RELIANCE GENERAL INSURANCE COMPANY LIMITED:

Indian Cover: +91-22-48903009 (Paid) / Global Cover: +91-22-67347844 (Paid)

RCare Health:	**Euro Assist Address:**
Claims and Care management Reliance General Insurance Company Limited, No. 1-89/3/B/40 to 42/KS/301-302, 3rd Floor, Krishe Block, Near Durgam Cheruvu Metro Station, Krishe Sapphire, Madhapur, Hyderabad, Telangana – 500081	Europ Assistance India Pvt Ltd. 7th Floor, Star Hub, Bldg No. 2, Near ITC Maratha Hotel, Sahar, Andheri East, Mumbai – 400 059, India

RCare ID:

For Indian Cover:	rgicl.rcarehealth@relianceada.com
For Global Claims Assistance:	reliance@europ-assistance.in

PEP DECLARATION:	
Are you a Politically Exposed Person (PEP)?	Yes / No
If yes, please mention the position held	
Is any of your close relation or family member a PEP?	Yes / No
If yes, please mention the name and relation and the position held by such close relative/family member.	

I hereby declare that in future if me, any of my close relatives or any of my family member attains a position of PEP then I shall confirm the same to Reliance General Insurance Co. Ltd as a mandate. I understand that this is a crucial information under the PMLA Rules and AML/ CFT Guidelines and shall confirm that the answers given by me is true. In case the company comes to know that this is a misrepresentation and concealment of information then the policy shall be put on hold for scrutiny by the company and I shall be solely responsible for the same.

Note :

"**Politically Exposed Persons" (PEPs)** shall have the meaning assigned to it under sub clause (db) of clause (1) of Rule 2 of the Prevention of Money Laundering (Maintenance of Records) Rules, 2005."

(db) "Politically Exposed Persons" (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials".

GENERAL DECLARATION:

I understand that as per the new AML/CFT Guidelines issued Reliance General Insurance Co. Ltd will be verifying my details pertaining to KYC and PAN provided at the time of proposal.

I further, do hereby agree and consent that in the case of the event of a mismatch of information provided by me in the proposal form, identification proof, and address proof at the time of issuance of the policy. I request Reliance General Insurance Company Limited to issue the policy with the details appearing as per my proposal form. I will be solely responsible for any consequences arising out of the difference in detail given by me during the verification of supporting documents provided by me at the time of issuance of the policy or otherwise.

AML Guidelines

1. I/We hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been /will be paid out of proceeds of crime related to any of the offense listed in Prevention of Money Laundering Act,2002.
2. I understand that the Company has the right to call for document to established sources of funds.
3. The Insurance Company has right to cancel the insurance contract in case I am/have been found guilty by competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India.

PROPOSER'S SIGNATURE *	**Date**	**Place**	**Time**
Verified by providing OTP number sent to registered mobile no. (9xxxxxxx33) at (HH:MM:SS) on DD-MM-YYYY and confirmed at (HH:MM:SS) on DD-MM-YYYY			

*Signature authentication: A One Time Password (OTP) authentication number has been sent on Your registered mobile number. By feeding in the said OTP number in the system, You hereby unconditionally and absolutely acknowledge and accept the declarations as stated above in its entirety, and the same would create a legally binding agreement between You and the Company.