

Claim No.: _____

COVID-19 PROTECTION INSURANCE - CLAIM FORM

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:	<input type="checkbox"/> Male <input type="checkbox"/> Female
e) Age:	YY / MM	f) Date of birth:	DD / MM / YYYY
g) Insured Address:			
City:		State:	
Pin Code:		Phone Number:	
Email ID:			

Diagnosis Cover	<input type="checkbox"/> Yes <input type="checkbox"/> No	Quarantine Cover	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss Of Employment*	<input type="checkbox"/> Yes <input type="checkbox"/> No (*If Applicable)
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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)
i) Claim form duly signed	i) Claim form duly signed	i) Claim form duly signed	i) Claim form duly signed
ii) COVID – 19 Report	ii) Hospital Discharge Summary	ii) Company LOP Certificate	ii) Termination Certificate
	iii) Final Bill	iii) Salary slip	
**	Travel Exclusion Cover	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes Provide Passport / Visa copy of the claimant
**	In Case of Death (Legal Heir certificate)	<input type="checkbox"/> Yes <input type="checkbox"/> No	



DETAILS OF CLAIMANT BANK ACCOUNT

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

PEP DECLARATION:

Are you a Politically Exposed Person (PEP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please mention the position held	
Is any of your close relation or family member a PEP?	<input type="checkbox"/> Yes <input type="checkbox"/> 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".

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.

Place: _____

Date: _____

Signature of Proposer**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.

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.

Place: _____

Date: _____

(Signature of Claimant)

HEALTH CARE ADDRESS:

Health Care Unit: Reliance General Insurance, No.1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad - 500081. **Email:** healthcare@indusindinsurance.com.