Bajaj Allianz General Insurance Company Limited
G.E. Plaza, Airport Road, Yerawada, Pune - 411006. Reg No.: 113. CIN: U66010PN2000PLC015329
E-mail: customercare@bajajallianz.co.in | Website: www.bajajallianz.com

Relationship Beyond Insurance

Global Personal Guard Policy (Individual)

Claim Form

Claim Number (For BAGIC Use Only)	
Regional /Branch Office Code	
Broker / Agent Name & Code	

Policy Details	
Name of the Insured	
Policy Number	
Address of the Insured	
Contact Number	

Details of the Insured Person (s) in respect of whom claim is made		
1.	Name of the Insured Person	
2.	Age	
3.	Gender	
4.	Date and time of Injury Sustained / Accident	
5.	Where did it happen?	
6.	How did the Accident Occur?	
7.	Nature of injury suffered (Please attached Doctor's certificate regarding nature of injuries)	
8.	Whether accident reported to Police? If Yes, FIR details:	☐ YES ☐ NO
9.	Has the accident resulted into loss of hand/s or foot/feet or eye/s permanent disability of any other type which may prevent the insured from engaging in or being occupied with or giving attention to any employment or occupation whatsoever? If yes, please give details	
10.	Whether Insured been taken to any hospital after the accident? If Yes, Address of the Hospital: (Please furnish proof of Hospitalisation like Discharge Summary from the Hospital, Certificate from the attending Medical Practitioner regarding injury necessitating hospitalisation)	☐ YES ☐ NO
11.	Date and Time of Admission in Hospital	
12.	Date and time of discharge from the Hospital	
13.	Name and Address of Surgeon in Attendance	
14.	Where and when can a Medical Officer of our company visit you, if necessary?	
15.	Do you have any other Personal Accident Policy? If Yes, kindly provide details:	☐ YES ☐ NO
16.	In case of Death of Insured Person, whether Post Mortem/ Autopsy has been done. If Yes, please attach Post Mortem Report / Autopsy Report and Death Certificate.	☐ YES ☐ NO

For which Base Covers do you want to claim? (Please tick (✓) the Appropriate Box)*

Please tick the appropriate Box	Name of Base Cover	Details (Kindly provide claims documents along with supporting bills (if required) for the claimed amount)
	Section I : Death	
	Section II: Permanent Total Disability	
	Section III: Permanent Partial Disability	

*All the above benefits are applicable for claims arising out of injuries due to accident. Please refer the policy wordings for details of each section.

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For which Optional Covers do you want to claim? (Please tick (✓) the Appropriate Box)**

Please tick the appropriate Box	Name of Optional Cover	Details (Kindly provide claims documents along with supporting bills (if required) for the claimed amount)
	Optional Cover I: Accidental Hospitalization Expenses	
	Optional Cover II: Adventure Sports Benefit	
	Optional Cover III: Air Ambulance Cover	
	Optional Cover IV: Children's Education Benefit	
	Optional Cover V: Coma Due to Accidental Bodily Injury	
	Optional Cover VI: EMI Payment Cover	
	Optional Cover VII: Fracture Care	
	Optional Cover VIII: Hospital Cash Benefit	
	Optional Cover IX: Loan Protector Cover	
	Optional Cover X: Loss of Income due to Disability from Accident	
	Optional Cover XI: Road Ambulance Cover	
	Optional Cover XII: Travel Expenses Benefit	

**All the above benefits are applicable for claims arising out of injuries due to accident. Please refer the policy wordings for details of each section.

Details of Primary Insured Bank's Account (Submission of Cancelled Blank Cheque Leaf with Payee Name Printed OR Copy of the First page of the Bank Passbook is Mandatory)

a. Name of the Account Holder (As per Bank Account):_____

b. Account no (As appearing in the cheque book): | | | | | | | | | | | | | | | | | |

c. Bank Name :_____

d. Branch Name & Address:_____

e. Account Type : Saving Current Cash Credit

f. MICR No. | | | | | | | | | | | |

g. IFSC Code: | | | | | | | | | | | |

h. PAN: | | | | | | | | | | | |

i. Cheque / DD Payable Details: | |

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 consent and authorize the Bajaj Allianz General Insurance Company or their representatives to seek information from any Hospital/ Medical Practitioner who has at any time attended concerning the claim.

Signature of the Claimant _____ **Date** ___ /___/ _____

Name of the Claimant _____