

<p align="center">The New India Assurance Company Limited <small>Regd & Head Office: New India Assurance Building, 87, M.G. Road, Fort, Mumbai - 400 001.</small></p> <p>Policy Issuing Office: Claims Hub, Mumbai Regional office - 2, Jeevan Seva, 2nd Floor, S.V. Road, Santacruz (W), Mumbai. 400054 Contact no.(022) 26590070 / 26590156</p>	
<p align="center">RuPay CARDHOLDER'S PERSONAL ACCIDENT INSURANCE CLAIM FORM 2023-24 Policy Number – 14230042230100000007 <small>THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS ADMISSION OF LIABILITY</small></p>	
<p align="center">ALL QUESTIONS ARE MANDATORY AND HAVE TO BE COMPULSORILY ANSWERED.</p>	
<p>RuPay CARD TYPE [PMJDY [OLD/NEW]]</p>	
NAME OF RUPAY CARDHOLDER	
AADHAR NUMBER OF CARDHOLDER	
BANK ACCOUNT NUMBER	
RUPAY CARD NUMBER	
A/c. Opening date in case of PMJDY account	
NAME OF NOMINEE [CLAIMANT]	
ADDRESS OF CLAIMANT WITH DISTRICT AND PINCODE	
DATE AND TIME OF ACCIDENT	
PLACE OF ACCIDENT	
BRIEF DESCRIPTION OF ACCIDENT [MANDATORY IN ENGLISH / HINDI]	
<p>IF SPACE IS INSUFFICIENT, PLEASE ATTACH SEPERATE SHEET.</p>	
NATURE OF CLAIM	DEATH / DISABLEMENT
ANY OTHER RuPay CARD HELD BY THE SAME PERSON	YES / NO
<p align="center"><small>IF YES PLEASE GIVE DETAILS</small></p>	

I hereby declare that the foregoing statements are made by myself and are true in all respect and that I have not attempted to conceal from the Company anything which it ought to be made acquainted and also that I have not abstained from any usual occupation longer than absolutely necessary and I agree that if I have made, or in any further declaration the Company may require, shall make any false or fraudulent statement or any suppression, concealment or untrue averment whatever, the Policy shall be void and my right to compensation forfeited and I 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.

BANK SEAL AND SIGNATURE		SIGNATURE OF CLAIMANT	
		MOBILE NUMBER OF CLAIMANT	

WITNESS CERTIFICATE

[TO BE FILLED UP AND SIGNED BY AN EYE WITNESS TO THE ACCIDENT IF ANY]

I hereby certify that I was present when the Accident occurred to Mr./ Ms. _____ on the _____ day of _____ 20__ in the manner stated by him/her over leaf, that it was caused by _____ which * was / was not his/her wilful act and that he /she * was / was not under the influence of intoxicating liquor at the time.

*Strike out which is not applicable

SIGNATURE & DATE

NAME OF WITNESS

ADDRESS

OCCUPATION

MEDICAL CERTIFICATE for DISABILITY CLAIMS ONLY

Disability Claims must be supported by medical evidence furnished by the Insured and at his expense.

NAME OF INJURED PERSON [CLAIMANT]	
SEX : [MALE / FEMALE]	AGE :
NATURE OF ACCIDENT	
WHETHER THE INJURIES ARE CONSISTENT TO THE DESCRIPTION OF ACCIDENT.	
DATE ON WHICH YOU FIRST ATTENDED THE CLAIMANT FOR THE INJURY	
HAS THE CLAIMANT BEEN DISABLED TOTALLY OR PARTIALLY	
IS THE CLAIMANT SUFFERING FROM ANY DISEASE/ ILLNESS/SYMPTOMS APART FROM THE INJURY WHICH MAY TEND TO RETARD RECOVERY? IF YES, PLEASE GIVE DETAILS.	
TYPE OF DISABILITY AS DEFINED IN ANNEXURE	

Having personally examined the above named Insured, I certify that the above statements are correct and that the insured person is necessarily disabled by the accident referred to

Signature: _____

Name & Qualification: _____

Address: _____

Date: _____

ANNEXURE

The Disablement	Compensation expressed as a percentage of Total Sum Insured.
1) Permanent Total Disablement	100%
2) Permanent and incurable insanity	100%
3) Permanent Total Loss of two Limbs	100%
4) Permanent Total Loss of Sight in both eyes	100%
5) Permanent Total Loss of Sight of one eye and one Limb	100%
6) Permanent Total Loss of Speech	100%
7) Complete removal of the lower jaw	100%
8) Permanent Total Loss of Mastication	100%
9) Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out Daily Activities essential to life without full time assistance	100%
10) Permanent Total Loss of Hearing in both ears	75%
11) Permanent Total Loss of one Limb	50%
12) Permanent Total Loss of Sight of one eye	50%
13) Permanent Total Loss of Hearing in one ear	15%
14) Permanent Total Loss of the lens in one eye	25%
15) Permanent Total Loss of use of four fingers and thumb of either hand	40%
16) Permanent Total Loss of use of four fingers of either hand	20%
17) Permanent Total Loss of use of one thumb of either hand:	
a) Both Joints	20%
b) One joint	10%
18) Permanent Total Loss of one finger of either hand:	
☛ Three joints	5%
☛ Two joints	3.5%
☛ One joint	2%
19) Permanent Total Loss of use of toes: a) All-one foot	
☛ Big-both Joints	15%
☛ Big-one joint	5%
☛ Other than Big- each toe	2%
20) Established non-union of fractured leg or kneecap	10%
21) Shortening of leg by at least 5cms	7.50%
22) Ankylosis of the elbow, hip or knee	20%