**Annexure 4**

# UNITED INDIA INSURANCE CO. LTD

*DO- XI, Maker Bhavan No.-01, 1st Floor, Sir V. T. Marg, Mumbai -400 020*

## *GROUP PERSONAL ACCIDENT/ AIR ACCIDENT CLAIM INTIMATION FORM*

***To be submitted for claiming Disability Cover on salary package account within 90 days after date of incident (Intimation may be advised through Email, Post, Telephone/ Fax)***

***Issuance of this format for intimation of a claim is not to be taken as an admission of liability.***

| | | |
|---|---|---|
| ***Policy No.*** | ***1203004219P114083561*** | *Address: DO – XI, Maker Bhavan No.1,1st floor, Sir V.T. Marg, Mumbai – 400 020.*<br>*Phone No.022- 22624525/22624818*<br>*Fax No. : 022-22624579*<br>*Email Id:*<br>120300@uiic.co.in*/ sbigpaclaims@gmail.com* |
| ***Policy Period*** | ***04 .01.2020 to 03.01.2021*** | |

| | | |
|---|---|---|
| *1* | *Name of Salary Account holder* | |
| *2* | *Address in full* | |
| *3* | *a) Date of Accident* | |
| | *b) Time of Accident* | |
| | *c) Place of Accident* | |
| | *d) Details of Accident* | |
| *4* | *Salary Package Account No.* | |
| *5* | *Type of Salary Package Account* | *# CSP/DSP/PMSP/ICGSP/SGSP/CGSP/PSP/RSP/SUSP* |
| *6* | *Variant of Salary Package A/c* | *Silver* ☐ *Gold* ☐ *Diamond* ☐ *Platinum* ☐ |
| *7* | *Name of Organization for DSP / PMSP / ICGSP/ PSP* | *@ Army / Air Force / Navy / Indian Coast Guard/ Assam Rifle / Rashtriya Rifle / BRO (GREF) / BSF / CRPF / CISF / ITBP / SSB / NSG/RPF/ NDRF/SPG* |
| *8* | *Name of the organization for others i.e. CGSP/SGSP/PSP/RSP/SUSP* | *Organization Name:*<br>*Place of work with name of State:* |
| *9* | *Personnel / Force/ Batch number in case of DSP / PMSP / ICGSP/PSP* | |

| | | | |
|---|---|---|---|
| *10* | *Details of organization and Regiment/ Unit No. in case of DSP/ PMSP/ ICGSP* | *Name:* | |
| | | *Unit No.* | |
| | | *Address:* | |
| | | *Contact details* | *Land Line No:*<br>*Mobile No:* |
| | | | *Email:* |
| *11* | *Details of SBI Branch where Salary Account was maintained* | *Branch Name:* | |
| | | *Branch Code:* | |
| | | *Place:* | |
| | | *State:* | |
| *12* | *Name of Nominee/Joint Account holder in the salary package account [If Available]* | | |
| *13* | *Relationship of Nominee with Account Holder* | | |
| *14* | *Address of the Nominee* | | |
| *15* | *E Mail ID of Nominee (if available)* | | |
| *16* | *Contact Number of Nominee (if available)* | | |

*[#Corporate Salary Package (CSP), Defence Salary Package (DSP), Para Military Salary Package (PMSP), Indian Coast Guard Salary Package (ICGSP), State Government Salary Package (SGSP), Central Government Salary Package (CGSP), Police Salary Package (PSP) and Railway Salary Package (RSP), Start-up Salary Package (SUSP)]*

***(@ Please tick on the appropriate organization)***

*The foregoing details are true to the best of my / our knowledge and belief.*

***Signature and name of Salary Package Account Holder/ person Intimating Claim:***

***Contact details of Person Intimating Claim***
***Landline No …….***
***Mobile No …….***
***Email ID …….***

**Annexure 9**

# UNITED INDIA INSURANCE CO. LTD.

*DO- XI, Maker Bhavan No.-01, 1st Floor, Sir V. T. Marg, Mumbai -400 020*

## PERMANENT TOTAL/ PARTIAL DISABILITY CLAIM FORM

*Issuance of this form is not to be taken as an admission of liability*

(To be filled in by the Salary account Holder)

| | | |
|---|---|---|
| *Policy No (A/c State Bank of India )* | **1203004218P113494902** | *Fax No. : 022-22624579*<br>*Phone No.* **: 022- 22624525/22624818** |
| *Policy Period* | ***04 .01.2020 to 03.01.2021*** | *Email Id:* ***120300@uiic.co.in/ vtsangtani@uiic.co.in***<br>***Correspondence Address****: United India Insurance Co. Ltd., Divisional Office–XI, Maker Bhavan No.1, Ist floor, Sir V.T. Marg, Mumbai – 400 020.* |

| | |
|---|---|
| **1. Name of the Salary Account Holder** | |
| **2. Occupation** | |
| **3. Name of the organization in case of DSP / PMSP / ICGSP/PSP** | |
| **4. Designation and Force No** | |
| **5. Salary Account No. with SBI** | |
| **6. Type of Salary Package Account** | **DSP/PMSP/ICGSP/PSP** |
| **7. Name & Code of SBI Branch** | |
| **8. Address of the Claimant** | |
| **9. Contact No & Email ID of Salary Account Holder** | |
| **10. Details of the Accident** | |
| **a. Date of accident:** | |
| **b. Time of accident:** | |
| **c. Place of accident:** | |

| | |
|---|---|
| **d. Particulars of accident:** | |
| **e. Details of injury/Loss/ (Tick the box)** | |
| ☐ **Sight of both eyes** | ☐ **separation of the two entire hands** |
| ☐ **separation of the two entire feet** | ☐ **one entire hand and one entire foot** |
| ☐ **Sight of one eye and such a loss of one entire hand or one entire foot** | |

f. **Permanent Partial Injury as below:**

| | | |
|---|---|---|
| **Loss of toes** | a. all<br>b. both phalanges<br>c. one phalanx<br>d. Other than great, of more than one toe lost each | |
| **Loss of hearing** | a. both ears | b. one Ear |
| **Loss of Fingers** | a. fingers and thumb of one hand<br>b. loss of 4 fingers | |
| **Loss of thumb** | a. both phalanges | b. one phalanx |
| **Loss of index finger** | a. 3 phalanges<br>c. one phalanx | b. 2 phalanges |
| **Loss of middle finger** | a. 3 phalanges<br>c. one phalanx | b. 2 phalanges |
| **Loss of ring finger** | a. 3 phalanges<br>c. one phalanx | b. 2 phalanges |
| **Loss of little finger** | a. 3 phalanges<br>c. one phalanx | b. 2 phalanges |
| **Loss of metacarpals** | a. first or second (additional)<br>b. third, fourth or fifth (additional | |
| **Any other permanent partial disablement** | as assessed by the Doctor | |

*I hereby declare that the foregoing statements made by me are true in all respects, that I have not attempted to conceal from the Company anything with which it ought to be made acquainted and that if I have made or in any further declaration the Company may require shall make any false or fraudulent statement or untrue averment whatever, the Claim shall be void and my right to compensation forfeited. I am willing if required, to make and provide to the Company a statutory Declaration of the whole of the foregoing statement or of any other statement made in connection with this claim.*

Signature of claimant.

Name: Date:

**Annexure 10**

# UNITED INDIA INSURANCE CO. LTD.

*DO- XI, Maker Bhavan No.-01, 1st Floor, Sir V. T. Marg, Mumbai -400 020*

## MEDICAL CERTIFICATE

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

| | | | |
|---|---|---|---|
| 1 | | **Details of Claimant (Salary Account Holder)** | |
| | a) | Name | |
| | b) | Sex | **Male:** **Female:** |
| | c) | Age | |
| 2 | | **Details of Accident** | |
| | a) | Nature of Accident | |
| | b) | Cause of Accident | |
| | c) | Whether the appearance of the injuries are consistent with account given of the accident | |
| 3 | | **Details of Injury/ loss** | |
| 4 | | Date on which you first attended claimant for this injury | |
| 5 | | Is claimant suffering from any diseases or illness apart from his injury and is there any illness by circumstances which may tend to retard recovery? If So give particulars? | |
| 6 | | Present Condition | |
| 7 | | How Long from the happening of the accident do you consider total disablement will last? | |
| 8 | | Name of Existing Doctor (if treatment is changed) | |
| | | | |

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

**Date** **Address**

**Name**

**Registration No** **Stamp**

**Qualification**

**Annexure 11**

*(On State Bank's Letter Head)*
*State Bank of India*

***Branch Name:*** ***Branch Code No:***

***Address:*** _____
***Email:***_____
***Telephone No:***

This is to certify that Shri/Smt/Ms._____
who has disabled on _____ due to accident (as per the documents enclosed), is a holder of Salary Package Account, the details of which are as under:

| | | | |
|---|---|---|---|
| 1 | Name of the **Salary Package Account holder** | : | |
| 2 | Address in full (as per Bank records) | : | |
| 3 | Date of Accidental | : | |
| 4 | Details of Injury/Loss as per Medical Certificate | | |
| 4 | Name of SBI Bank Branch where the Salary Package Account is maintained | : | |
| 5 | Type of Salary Package account | : | |
| 6 | Claim amount under Personal Accident/ | : | |
| 7 | Phone No. | : | |
| 8 | Email ID | : | |

The Bank or its Officers will not be held responsible for the genuineness/authenticity of documents like FIR, Death Certificate, Post Mortem report, etc, being submitted by the claimant to the Insurance Company. It shall be the responsibility of the Insurance Company to ascertain their authenticity. All further correspondence should be made directly between the claimant and the Insurance Company. The claim settlement will be entirely the responsibility of Insurance Company. All settlements/disputes will be between the claimant and the Insurance Company and the Bank will not be a party to such disputes.

**For State Bank of India,**

**Signature of Branch Manager**
**SS No.**
**Branch Name:**
**Branch Code:**