

Annexure 4

NATIONAL INSURANCE COMPANY LTD

PERMANENT TOTAL/ PARTIAL DISABILITY CLAIM FORM

GROUP PERSONAL ACCIDENT - Civilian Salary, Pension and Deposit Account Holders of Bank of Baroda

To be submitted for claiming Personal Accident Insurance (PAI) Disability within 180 days from date of Accident of Account holder of Bank of Baroda (Intimation may be advised through Email, Registered Post, Fax). Death/Disability due to Accident only is covered under the Policy and account should be under Insurance Package as on date of accident/death/disability)

(Disclaimer: Issuance/acceptance of this format should not to be taken as an admissibility of any liability.)

<i>Policy No. (A/c Bank of Baroda Bank)</i>	340100422410000046	<i>Address (Documents to be submitted to):</i> National Insurance Company Ltd
<i>Policy Period</i>	Policy effective from 00.00 hours, on 12-08-2024 to midnight of 11-08-2025	Corporate Business Office, Delhi Regional Office IV, 803 -B, Tower 3, 8th floor, Konnectus Building opp New Delhi Railway Station Ajmeri Gate Bhavbhuti Marg, New Delhi- 110002. Kind Attention: Misc-GPA Claim Dept. / 340100 (Visit us: https://nationalinsurance.nic.co.in/contact-us)

1. Name of the Account Holder	
2. Occupation	
3. Type of account (Civilian Salary, Pension and Deposit Account Holders)	
4. Account No with Bank of Baroda Bank	
5. Name & Code of Bank of Baroda Branch	
6. Address of the Claimant	
7. Contact No & Email ID of Account Holder	Mobile: E-mail ID:
8. PAN & AADHAR of the Claimant	
9. Hospitalization Details	

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) - Disability Certificate from Medical Board of Government Hospital at State/District Level or any other competent Authority (as per Gov. of India, Direction)	
<input type="checkbox"/>	Sight of both eyes	<input type="checkbox"/> Separation of the two entire hands
<input type="checkbox"/>	Separation of the two entire feet	<input type="checkbox"/> One entire hand and one entire foot
<input type="checkbox"/>	Sight of one eye and such a loss of one entire hand or one entire foot	<input type="checkbox"/> Others
f. Permanent Partial Injury as below:		
Loss of toes	a. all b. both phalanges c. one phalanx 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 b. loss of 4 fingers	
Loss of thumb	a. both phalanges b. one phalanx	
Loss of index finger	a. 3 phalanges c. one phalanx b. 2 phalanges	
Loss of middle finger	a. 3 phalanges c. one phalanx b. 2 phalanges	
Loss of ring finger	a. 3 phalanges c. one phalanx b. 2 phalanges	
Loss of little finger	a. 3 phalanges c. one phalanx b. 2 phalanges	
Loss of metacarpals	a. first or second (additional) b. third, fourth or fifth (additional)	

Any other permanent partial disablement	as assessed by the Doctor
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#Do not leave any fields blank, mark NA where not applicable. All Pages to be signed.

*Declaration: I/We 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/we 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/We also understand and confirm that the settlement of this claim is to be done through Bank of Baroda and I/we will have 'No Objection' if Insurance company pay the final settlement of this claim to Bank of Baroda.***

I/We understand the above provided details shall be subject to verification for the insurance claim requirement. I/We also acknowledge that merely issuance/acceptance of this form does not establish acceptance of any liability.

I/We am/are willing if required, to make and provide to the Insurance Company a statutory Declaration of the whole of the foregoing statement or of any other statement made in connection with this claim.

Full Signature of Insured :

Contact Detail :

Note: The above requisite details/documents (in the attached list) are not exhaustive and any necessary details/Documents may be sought at the time of Claim Process/Investigation. All coverages as per the Policy.

Annexure 5

MEDICAL CERTIFICATE (From Registered Medical Practitioner)

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

Details of Claimant (Account Holder)					
1	a)	Account Number			
	b)	Name			
	c)	Sex	Male: Female:		
	d)	Age			
2		Details of Accident			
	a)	Nature of Accident			
	b)	Cause of Accident			
	c)	Whether the appearance of the injuries is 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			

DOCUMENTS TO BE SUBMITTED ALONG WITH DISABILITY CLAIM FORM

SR No.	Documents	Enclosed (Yes / No)		Documents	Enclosed (Yes / No)
I	Annexure 1: Claim Form		VIII	MLC copy (wherever available)	
II	Annexure 2: Bank Certificate Duly stamped and signed Certificate by Bank of Baroda Branch Manager on Bank Letter head.		IX	Bank Certified copy of the first page of the Bank Passbook or canceled Cheque containing the Name of Account Holder (claimant), IFSC Code of the Bank, Bank Account Number of Nominee/Joint Account holder/ Claimant	
III	Annexure 3: Bank Details/NEFT Form of Nominee/Joint Account /Claimant holder in the account		X	Driving License (in case of Deceased Driving Vehicle)	
IV	Annexure 4: Disability Claim Form		XI	Vernacular Language Document in English Translation (Notarised copy)	
V	Annexure 5: Attested Copy of Medical Certificate		XII	Salary/Pension/Income Proof (at least of 3 Months)	
VI	PAN Card copy of the Nominee/Joint Account holder/ Claimant in the account. if not available, then form 60		XIII	Notarized copy of Disability Certificate from the Competent Authority - Medical Board of a Government Hospital at District/State Level or any other competent Authority (as per Gov. of India, Direction)	
VII	Attested Copy of FIR Report (Legible Copy)		XIV	Aadhar Card of Nominee/Joint Account holder /Claimant in the account	
VII	Certified Copy of Final Police Investigation Report in case of train accident/drowning/murder (Legible Copy)		XV	All Hospitalisation Record (Case Summary, Medical Records etc.) Any other Document necessary at the time of Claim Processing/Verification	