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 (Only for SBI)

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* *Phone No.* **: 022- 22624525/22624818** *Email Id:* ***120300@uiic.co.in/ vtsangtani@uiic.co.in*** ***Correspondence Address****: United India Insurance Co. Ltd., Divisional Office–XI, Maker Bhavan No.1, Ist floor, Sir V.T. Marg, Mumbai – 400 020.*
Policy Period	***04 .01.2019 to 03.01.2020***	

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 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	

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.

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 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, **Date:**

…… Branch)

Branch Manager
SS No.