



## The New India Assurance Company Limited

Regd & Head Office: New India Assurance Building, 87, M.G. Road, Fort, Mumbai - 400 001.

Policy Issuing Office : Bandra Divisional Office 142300  
C-6,NCL Business Premises, 1<sup>st</sup> Floor, Bandra-Kurla Complex, Mumbai 400051.  
Contact no.(022) 26591702(Direct) / 26590156

### RuPay CARDHOLDER'S PERSONAL ACCIDENT INSURANCE CLAIM FORM

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS ADMISSION OF LIABILITY

|                               |                     |
|-------------------------------|---------------------|
| POLICY NUMBER                 |                     |
| RuPay CARD TYPE               | PREMIUM/NON-PREMIUM |
| RuPay CARD NUMBER             |                     |
| D/o issue & last D/o swapping |                     |
| CLAIM NO.                     |                     |

#### TO BE COMPLETED BY THE INSURED / CLAIMANT

- 1) a. NAME,ADD & CONTACT NO.OF MEMBER BANK :  
b. NAME OF INSURED PERSON :  
c. ADDRESS IN FULL :  
d. PROFESSION OR OCCUPATION :  
e. AGE AT LAST BIRTHDAY :

- 2) BRIEF DISCRIPTION OF ACCIDENT :

- 4) PARTICULARS OF ACCIDENT  
a.i) DATE OF ACCIDENT :  
a.ii) TIME OF ACCIDENT :  
a.iii) PLACE OF ACCIDENT :  
a.iv) NAME & ADDRESS OF WITNESS :

- 5) NATURE OF CLAIM : [ **DEATH / PERMANENT DISABLEMENT** ]

- 6) NATURE OF DISABLEMENT :  
[ SPECIFY DISABILITY AS PER COVERAGE]

PRESENT STATE OF INCAPACITY :

- 7) NAME AND ADDRESS OF SURGEON IN ATTENDANCE :

|   |    |                                                                               |  |
|---|----|-------------------------------------------------------------------------------|--|
| 8 | a. | WHERE AND WHEN CAN A MEDICAL OFFICER OF THE COMPANY VISIT YOU, IF NECESSARY ? |  |
|   | b. | NAME OF NEAREST RAILWAY STATION AND DISTANCE THEREFROM                        |  |
| 9 | a. | ARE YOU HOLDER OF ANY OTHER RuPay CARD, IF YES THEN NO. OF RuPay CARD/S HELD  |  |
|   | b. | IF SO, STATE NAME/S OF MEMBER BANK                                            |  |

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.

|           |  |                      |  |
|-----------|--|----------------------|--|
| WITNESS   |  | SIGNATURE OF INSURED |  |
| SIGNATURE |  | DATE                 |  |
| NAME      |  |                      |  |
| ADDRESS   |  |                      |  |

### CERTIFICATE TO BE FILLED UP AND SIGNED BY AN EYE WITNESS TO THE ACCIDENT

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 willful 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             |  |
| ADDRESS          |  |
| OCCUPATION       |  |

### MEDICAL CERTIFICATE

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

|    |     |                                                                                                                                                                                                |         |         |
|----|-----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------|
| 1. | (a) | Name of Claimant                                                                                                                                                                               | (b) Sex | (c) Age |
| 2. | (a) | Nature and cause of accident                                                                                                                                                                   | :       |         |
|    | (b) | If injury to eye or limb, whether one(state left or right) or both                                                                                                                             | :       |         |
|    | (c) | Whether the appearance of the injuries are                                                                                                                                                     |         |         |
|    |     | Consistent with the description the accident                                                                                                                                                   | :       |         |
| 3. |     | Date on which you first attended Claimant for this injury                                                                                                                                      | :       |         |
| 4. |     | Has the Claimant been disabled totally or partially ? :                                                                                                                                        |         |         |
| 5. |     | If partial disability, please specify %age :                                                                                                                                                   |         |         |
| 6. |     | Is the Claimant suffering from any disease or illness apart from the Injury? Is the claimant suffering from any illness/symptoms which may tend to Retard Recovery ? If so, give particulars : |         |         |

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 : \_\_\_\_\_

### Declaration from the Member Bank (on bank's letter head)

This is to hereby confirm that Ms. / Mr. \_\_\_\_\_ was issued RuPay card no. \_\_\_\_\_

[illegible]

by our bank and as per the bank records the nominee details of the card holder is as mentioned below along with the NEFT details of the nominee and details of transaction performed by cardholder within 45 days prior to date of accident including accident date.

Card Holder Name:

RuPay Card Type (Non-Premium / Premium):

Nominee Name\*:

Relationship with the nominee:

Bank Account No.:

IFSC Code:

Whether Cardholder has performed any transaction at any Merchant Establishment/ATM /ecommerce /Micro ATM/Business Correspondent of the bank at locations within 45 days prior to date of accident including accident date (Yes/No):

Please provide switch log / core banking screenshot for transaction verification and highlight card number/customer name and attach as annexure (bank seal and duly signed)

Branch Name:

Branch Address and contact numbers:

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Contact Person: \_\_\_\_\_

Contact Person Address and phone numbers:

**Authorized Signatory and Bank Seal**

*\* Please Note - In case of nominee details not available, legal heir certificate as per competent court order to be provided by the beneficiary and attached to the documents by bank while submitting to The New India Assurance Co. Ltd.*

We hereby confirm that Ms. / Mr. \_\_\_\_\_ aged \_\_\_\_ years, holder of Account no. \_\_\_\_\_ was issued the below mentioned RuPay card by our Bank.

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As per our records, on \_\_\_\_\_ (Transaction date), the customer has performed Transaction at \_\_\_\_\_ branch, details of which are given below.

**Details of Customer induced transaction at the Bank branch :** \_\_\_\_\_

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The transaction fulfils the usage criteria of (45/90)\* days : **Yes / No**

\*45 days Usage criteria is for RuPay Premium card holders.

\*90 days Usage criteria is for RuPay Classic card holders.

**Bank Official's details:**

a) Branch Official Name: \_\_\_\_\_

b) Bank Name: \_\_\_\_\_

c) Branch Name: \_\_\_\_\_

d) Contact Number:

i. Mobile: 

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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ii. Tel: 

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iii. email: \_\_\_\_\_

I/We hereby solemnly affirm that the above statements are true and correct to the best of my /our knowledge and belief.

**(Authorized signatory)**

Seal of the Bank branch

Date:

Note: Settlement of claims is as per the terms and conditions of the Insurance company.