बार कौंसिल आफ उत्तर प्रदेश
दुर्घटना बीमा योजना

आवश्यक निर्देश

1. जिन अधिवक्ताओं की दुर्घटना में दिनांक 15.09.2010 के बाद मृत्यु हुई है अथवा शरीर का कोई अंग पूर्णतः नष्ट हो गया है। केवल उन्हीं अधिवक्ताओं के दावों पर यह फार्म मान्य होगा।
2. संलग्नक फार्म का फोटो स्टेट कराकर दो प्रतियां भरकर भेजें।
3. वांछित सभी प्रमाण–पत्रों की दो–दो प्रतियां संलग्न करें।
4. अपूर्ण आवेदन पत्र यदि इन्योरेंश कम्पनी द्वारा निरस्त होता है तो हमारे कार्यालय की कोई जिम्मेदारी नहीं होगी।
5. दुर्घटना तिथि से 6 माह के अन्दर दावा फार्म कार्यालय को प्राप्त हो जाना चाहिए।

वांछित प्रमाण–पत्र

इस आवेदन पत्र के साथ निम्नलिखित प्रमाण–पत्र अवश्य संलग्न करें।

1. मृत्यु की दशा में पोस्ट मार्टम रिपोर्ट की दो प्रमाणित प्रतियां।
2. प्रथम सूचना रिपोर्ट (एफ0आई0आर0) की दो प्रमाणित प्रतियां।
3. शरीर का कोई अंग पूर्ण रूप से नष्ट होने पर मुख्य चिकित्सा अधिकारी का प्रमाण–पत्र।
4. मृत्यु प्रमाण–पत्र।
5. बार एसोसिएशन के अध्यक्ष/मंत्री महोदय का अधिवक्ता के रूप में कार्यरत होने का प्रमाण–पत्र।
6. बार कौसिंल आफ उत्तर प्रदेश द्वारा प्रदत्त अधिवक्ता प्रमाण–पत्र की दो प्रमाणित प्रतियां।
7. उत्तराधिकारी का एक इस आशय का शपथ पत्र जिसमें दुर्घटना का पूर्ण विवरण हो।

RELIANCE General Insurance
Anil Dhirubhai Ambani Group

PERSONAL ACCIDENT INSURANCE CLAIM FORM

The issue of this form does not constitute admission of liability. Please return the form completed within Fourteen days of the loss together with the relevant vouchers, documents etc.

Policy No.	Claim No.		
	Date of Registration		
Area Officer Code/Service Center Code:			
Broker / Agent Name:		Code:	

1.Name of the Insured 2.Customer ID					
3.Address of the Insured	Plot No/Door No.		Building Name		
	Road				
	Area				
	City		Pin code		
	State				
	Phone No.				
	E-mail Id				
4.Profession or Occupation					

Policy Detail			
Sum Insured		Table of Cover	

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Detailed of Accident

5. a) Name of the Insured Person dead injured in the accident. b) Relationship with the employee / member c) Employee / member identification no	Self / Spouse / Children

6. a) date of accident: b) Time of accident c) Place of accident: d) name & address of the witness:	

7.Particulars of the accident:	
8.Nature of injury received (if any to limb or eye state whether right or left)	

9. a) Nature of disablement b) Extent of disablement c) Period of temporary total disablement d) Present state of incapacity	(From…….to…….)
10. Name and address of surgeon in attendance	
11. Where and when can a Medical Officer of this Company visit you, if necessary?	
12. a) Are you insured in any other officer to officers of the Company or any other company, granting compensation for accident? b) If so state and name and address of company or companies and amount of insurance.	

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I /We hereby declare that the forgoing statement made by me / us are true in all respects, that I / we 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 nature averment whatever, the Policy shall be void and my / our right to compensation forfeited. I am / we are 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.

Witness: Name…....

Signature……..

Signature of the Insured

Name……

Address……

…….

Date:

RELIANCE General Insurance
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Medical Certificate

(Claim must be support by medical evidence furnished by the Insured at his / her expense)

1. a) Name of Claimant b)Age

1. b) If two eyes or limb, state left or right

c) Whether the appearance of the injuries are consistent with the account given of the accident.

2. Date on which you first attended claimant for this injury

3. Has claimant been totally prevented from attending to any portion of his business? If so, for how long?

4. Is claimant suffering from any disease or illness apart of from his injury and is there any illness by circumstances which may tend to retard? If so, give particulars.

5. Present condition.

6. How long from the happening of the accident do you consider?

a) Total disablement will last

b) Partial disablement will last

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

Signature:

Name:

Qualification:

Address: