भाविकांची विमा पॉलिसी

श्री. विठ्ठल रूक्मिणीच्या दर्शनासाठी आलेल्या भाविकांसाठी मंदिर समितीच्या वतीने दि.०८/०७/२०१९ ते दि.०७/०७/२०२० या कालावधीत विमा (क्षेत्र – पंढरपूर नगरपालिका क्षेत्र, ६५ एकर जमीन क्षेत्र, श्री. विठ्ठल रूक्मिणी मंदिर व परिसर, दर्शनरांग, टाकळी, गोपाळपूर, भटुंबरे, शेगाव दु. व वाखरी पालखी तळ) दि ओरिएंटल इन्शुरेंस कंपनी लिमिटेड, ४४२, पश्चिम मंगलवार पेठ, सोलापूर यांच्यामार्फत उतरविण्यात आलेला आहे. त्याचा सविस्तर तपशिल खालीलप्रमाणे आहे.

- अपघाताने मृत्यू झाल्यास (२५ भाविक × रू.२,००,०००/–) – रू.५०,००,०००/–
- अपघाताने दोन अवयव निकामी झाल्यास (२५ भाविक × रू.१,००,०००/–) – रू. २५,००,०००/–
- अपघाताने एक अवयव निकामी झाल्यास (२५ भाविक × रू.५०,०००/–) – रू. १२,५०,०००/–
- अपघाताचा दवाखाना खर्च (२५ भाविक × रू.२५,०००/–) – रू.६,२५,०००/–

(एकूण विमा रक्कम रू.९३,७५,०००/–)

त्यासाठीचा करावयाचा अर्ज व सोबत जोडावयाच्या कागदपत्रांचा तपशिल खालीलप्रमाणे आहे.

1. **Claim Form**
2. **Jawab / and First Information Report.**
3. **Spot Panchnama**
4. **Inquest Panchnama**
5. **Original Death Certificate**
6. **Post Mortem Report**
7. **Legal Heirs certificate.**
8. **Final Investigation Report of Police CRPC 174 with granting summary.**
9. **Medical Certificate from treating doctor**
10. **Driving Licence of Deceased, if in the Accident vehicles are involved &/ or deceased was Driving Vehicle....**
11. **Two I/D proof of deceased Person with age proof.**
12. **Two I/D proof of legal heir's**
13. **Please send the written intimation.**
14. **Written intimation from legal heirs and mandir**
15. **Pan Card**
16. **Aadhar Card**
17. **Bank Passbook**

PERSONAL ACCIDENT CLAIM FORM

दि ओरिएण्टल इंश्योरेंस कम्पनी लिमिटेड
THE ORIENTAL INSURANCE CO. LTD.

(A GOVERNMENT OF INDIA UNDERTAKING)

REGD. OFFICE : Oriental House, P.B. NO. 7037, A-25/27, Asaf Ali Road, New Delhi - 110 002.

This form issued without admission of liability and must be completed and returned within seven days after its receipt. No claim can be admitted unless a **Medical Certificate** overleaf be furnished at the Claimant.

Claim No. ________________	Policy No. ________________
1. Name in full ________________ Residence ________________ Business Address ________________ Present Business or Occupation if more one, state all	Present Age ______ Year Height ______ M Cms. Weight at ______ Kgs.
2. (a) When and how did accident occur ? State day, date and hour. (b) Where did it occur? (c) Give full particular of the cause and the injuries sustained.	
3. Give name and address of the witness of the accident.	
4. (a) Give name and address of the doctor who attended you. (b) Give name and address of the usual Medical Attendant.	
5. State where and when a Medical or other officer of the Company can visit you, if necessary.	
6. (a) State the number of days you have been necessarly and entirely confined to Bed Room or House as the sole and direct result of the injuries sustained and disabled from engaging in any employment or occupation of any description whatsoever for ____________ days from __________ to __________ (Both inclusive)	
(b) Have you in any way attended to business or working during the above period ?	
(c) If you have been able to attend to any portion of your business or occupation Please state from what date.	
7. Have you previously claimed or received compensation under an Accident and/or Sickness Policy? If so please, give Particulars.	
8. (a) Are you insured elsewhere ? (b) If so please give full details of such company or insurer and amount you are entitled to claim.	

I HEREBY DECLARE that I have received the injuries above described and warrant the truth of the foregoing particulars in every respect and I have made, or it shall fails or under statement, suppression or concealment my right to compensation shall be absolutely forfeited.

I claim to be paid sum of ________________ per week or the total sum of ________________ which I agree to accept in full settlement of my claim on the Company.

Date ________________ 20

Signature ________________

PRIVATE AND CONFIDENTIAL

दि ओरिएण्टल इंश्योरेंस कम्पनी लिमिटेड
THE ORIENTAL INSURANCE CO. LTD.

(A GOVERNMENT OF INDIA UNDERTAKING)

REGD. OFFICE : Oriental House, P.B. NO. 7037, A-25/27, Asaf Ali Road, New Delhi - 110 002.

Note : This form is to be completed by the **Claimant's Medical Attendant** whose replies should be full as possible.

Policy No. ______	Claim No. ______
1. CLAIMANT Name in full ______ Age ______	
2. The nature and extent of injuries : (if to a limb state whether right or left)	
3. The cause of the accident, so far as known to you.	
4. (a) Date of your first attendance upon him in conseqence of the injuries sustained.	
(b) Are you still in attendance ?	
5. Are you his usual Medical Attendant and if so how long have you known him, and for what have you been attended him ?	
6. (a) Are the symptoms (i) due exclusively to the accident or (ii) traceable to disease infirmity or any other cause.	
(b) Has he ever suffered from Govt. Rheumatism, Diabetes or Fits ?	
(c) Is there anything in his medical history which may have contributed directly or indirectly, to the accident or which may likely to retard his recovery ?	
(d) Have you any reason to suppose that he was under the influnce of intoxicants at the time of the accident ?	
7. (a) State the time within your own knowledge that the claimant has been as the direct and sole fined consequence of the injuries sustained necessarily confined to his house.	
(b) If still so confined state to which and the probable duration or confinement to	
8. (a) Has he been able to attend to any portion of his business or occupation ?	
(b) If so, from what date	
(c) If not, please state probable date (i) of his being so able (ii) of his complete recovery	
9. Is there now and disability ? If not please give date of recovery	
10. Any further recovery	

I hereby certify that the above named met with the accident referred to and that the foregoing are correct. Date ______

Signature ______ Qualification ______

Address ______

Doctor's Seal
or Rubber Stamp

MISC - 88-Ketan-1x50-150 Pkts-08-10

अपघाताची सूचना

नाव:- ______________________________

पत्ता:- ______________________________

____

____

फोन नंबर:- ______________________________

दिनांक:- ______________________________

प्रति,
विभागीय अधिकारी
दि ओरिएंटल इन्शुरेंस कंपनी लिमिटेड
सोलापूर

विषय:- पॉलिसी नंबर १६१९००/४८/२०१७/१६७९
श्री. ______________________________
याना अपघात झाल्याबाबत.

महोदय,

वरील विषयास अनुसरून आपणास कलविण्यास खेद वाटतो की, वर उल्लेख केलेल्या व्यक्तिस दिनांक ______________ रोजी ठिक ______________ वाजता अपघात ---------------------------------------
-- ठिकाणी झाला आहे.

अपघाताचे स्वरूप :-

तरी सदर दाव्याबाबत योग्य ती पुढील कार्यवाही करावी ही विनंती

आपला विश्वासू