**Annexure 4**

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**UNITED INDIA INSURANCE CO. LTD**

**PERMANENT TOTAL/ PARTIAL DISABILITY CLAIM FORM**

*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.* | ***1202004225P101336111*** | Address: (Documents to be submitted to):  United India Insurance Co. Ltd  Property & Casualty claims hub  Maker Bhavan no. 1,1st Floor, Sir V.t Marg,  New Marine Lines, Churchgate,  Mumbai-400020 Maharashtra  Email ID - [120093@uiic.co.in](mailto:120093@uiic.co.in)  Land Line Number - 022-22624526,22642294 (Ext- 231) |
| *Policy Period* | *10.04.2025 to 09.04.2026* |

|  |  |  |
| --- | --- | --- |
| 1. **Name of the Salary Account Holder** | |  |
| 1. **Occupation** | |  |
| 1. **Name of the organization in case of Defence / Police / Others** | |  |
| 1. **Type of Salary Package Variant (Silver, Gold, Diamond, Platinum)** | |  |
| 1. **Designation and Force No** | |  |
| 1. **Salary Account No. with Canara Bank** | |  |
| 1. **Customer ID** | |  |
| 1. **Type of Salary Account** | |  |
| 1. **Name & Code of Canara bank Branch** | |  |
| 1. **Address of the Claimant** | |  |
| 1. **Contact No & Email ID of Salary Account Holder** | |  |
| 1. **Details of the Accident** | |  |
| * 1. **Date of accident:** | |  |
| * 1. **Time of accident:** | |  |
| * 1. **Place of accident:** | |  |
| * 1. **Particulars of accident:** | |  |
| * 1. **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** | | **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 b. 2 phalanges  c. one phalanx | |
| **Loss of middle finger** | a. 3 phalanges b. 2 phalanges  c. one phalanx | |
| **Loss of ring finger** | a. 3 phalanges b. 2 phalanges  c. one phalanx | |
| **Loss of little finger** | a. 3 phalanges b. 2 phalanges  c. one phalanx | |
| **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.*

Name:

Signature of claimant Date:

**Annexure 5**

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**UNITED INDIA INSURANCE CO. LTD**

**MEDICAL CERTIFICATE**

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Details of Claimant (Salary Account Holder)** | | | | | |
| 1 | a) | Salary 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** |  |  |  |  |

**Annexure 6**

**BANK CERTIFICATE**

***(To be printed on the bank Letter head)***

This is to certify that Shri/Smt/Ms.---------------------------------- who has got disabled on --------------------- due to accident (as per the documents enclosed), is a holder of Salary Package Account, details thereof are as under:

|  |  |  |  |
| --- | --- | --- | --- |
| 1 | Name of the **Salary Package Account holder** | : |  |
| 2 | Salary Package Account No. | : |  |
| 3 | Customer ID |  |  |
| 4 | Address in full (as per Bank records) | : |  |
| 5 | Date of Accidental | : |  |
| 6 | Details of Injury/Loss as per Medical Certificate |  |  |
| 7 | Name of Canara Bank Bank Branch where the Salary Package Account is maintained | : |  |
| 8 | Type of Salary Package account (Defence, Police, Others) | : |  |
| 9 | Type of Salary Package Variant (Silver, Gold, Diamond, Platinum) |  |  |
| 10 | Claim amount under Personal Accident/ | : |  |
| 11 | Phone No. | : |  |
| 12 | Email ID | : |  |

The Bank or its Officers will not be held responsible for the genuineness/authenticity of documents like FIR, Death Certificate, Postmortem 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 disposal will be 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 Canara bank,**

**Signature of Branch Manager**

**Branch Manager Name:**

**Branch Code:**

**Branch Stamp**