

FORM-II:

Personal Accident Insurance Claim Form for accidental loss of life on account of COVID-19 related duty



The New India Assurance Company Limited

Regd. & Head Office : New India Assurance Bldg., 87, Mahatma Gandhi Road, Fort, Mumbai - 400 001.

The issuance of this form is not to be taken as an admission of Liability

Personal Accident Insurance Claim Form (Particulars of Accident)

Policy No.

TO BE COMPLETED BY THE CLAIMANT

Name of the Insured: Secretary, Ministry of Health and Family Welfare, Government of India, New Delhi

1. Details of Deceased who died in the accident :

- (a) Full name (Ms./Mr.) _____
- (b) Father's name _____
- (c) Age at last birthday _____
- (d) Sex _____
- (e) Address _____
- (f) Profession/occupation _____

2.	(a) Date of the accident (b) Time of accident (c) Place of accident	
3.	FIR Number :	
4.	(a) Date and Time of Death (b) Has Post-mortem been conducted	
5.	Name and Relationship of the claimant with the deceased	

6. Electronic Clearing Service (ECS) Details of the Claimant:

6.1	Name of the Claimant (as per the Bank Account)	
6.2	Relationship with the Deceased	
6.3	Bank Name	
6.4	Branch and address	
6.5	Bank Account No.	
6.6	Bank Account Type	
6.7	IFSC Code	
6.8	MICR Code	

I, _____ hereby declare that the foregoing statements are true in all respect and that I, the claimant have not attempted to conceal from the Company anything which it ought to be made acquainted. 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 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 a connection with this claim.

I also declare that the Deceased Person met with the accident while engaging in the work of attending to the patients suffering from Corona Virus (COVID 19).

	Claimant	Witness
Name :		
Address :		
Contact number :		
Date:		
Signature:		

Place and Date:

Signature of the Claimant

1. DOCUMENTS TO BE SUBMITTED ALONG WITH CLAIM FORM

- I. Identity proof of Deceased (Certified copy)
- II. Identity proof of the Claimant (Certified copy)
(Must fulfil clause 3 of this Form)
- III. Proof of relationship between the Deceased and the Claimant (Certified copy)
- IV. Death summary by the Hospital where death occurred (in case death occurred in hospital) (Certified copy).
- V. Death Certificate (in Original)
- VI. Post-mortem Report (Certified copy)
- VII. Cancelled Cheque (desirable) (in Original)
- VIII. FIR (Certified copy)
- IX. Certificate by the Healthcare Institution/ organization/ office, as under:
 - A. Those employees (Regular/Adhoc/Contractual/Daily Wagers/retired Government Officials/ Private individuals) engaged by-**
 - **Health care facilities of Central/State/UT Governments/ Urban Local Bodies**
 - **Autonomous / PSU hospitals of Central/State / UT Government, AIIMSs, INIs and Hospitals of Central Ministries.**
 - (i) Certificate of employment/engagement by the Head of Institution/ organization/office indicating that the Deceased was an employee of/engaged by the Institution.
 - (ii) Certify and submit proof that the deceased had accidental loss of life on account of COVID-19 related duty.
 - B. Private healthcare Institution:**
 - (i) Certificate of Employment by the Director / Medical Superintendent / Head of the Institution.
 - (ii) Certify and submit proof that the deceased had accidental loss of life on account of COVID-19 related duty.
 - C. Private person engaged by the Health Care Institutions / Organisations (both public and private) through an Agency:**
 - (i) Certified copy of the document indicating that the services of the Agency were engaged by the Institution / Organisation.
 - (ii) Proof of engaging the services of individual by the Agency.
 - (iii) Certify and submit proof that the deceased had accidental loss of life on account of COVID-19 related duty.
 - D. Community Health Workers (ASHAs and ASHA Facilitators)**
 - (i) Certificate of engagement as ASHA/ASHA Facilitator provided by the Medical Officer of Primary Health Centre (PHC).
 - (ii) Certificate by Medical Officer of Primary Health Centre (PHC) that

ASHA/ASHA Facilitator had accidental loss of life on account of COVID-19 related duty.

E. Volunteer drafted for COVID 19 related responsibilities by the Government officials authorized by the State/UT Government.

- i. Proof of engaging the services of individual by the Government officials authorized by the State/UT Government.
- ii. Certify and submit proof that the deceased had accidental loss of life on account of COVID-19 related duty.

2. CLAIM CERTIFYING AUTHORITY

2.1 Claims related to a particular State/UT would be certified and forwarded by the Director General Health Services /Director Health Services/ Director Medical Education or any other Official specifically authorised by the State/UT Government for this purpose.

2.2 Claims related to health care facilities of Central Government, Central Autonomous / PSU Hospitals, AIIMS, INIs and Hospitals of other Central Ministries, would be certified and forwarded by Director or Medical Superintendent or Head of the concerned institution.

3. CLAIMANT

3.1 In cases where the deceased was a Govt. servant (both serving and retired) of Central and State, or employee of Urban Local Body, insurance claim to be submitted by a person appointed as nominee for Death cum Retirement Gratuity (DCRG) as per service record of the deceased and is to be certified by the concerned office.

3.2 For others, who are not covered under 3.1, are to be governed by the priority list as being followed for deciding Railway accident claims.

4. CLARIFICATION

In case of any clarification on matter of interpretation, the decision of Ministry of Health and Family Welfare, Government of India shall be final.
