Annexure 4

Tata AIG General Insurance Co. Ltd.

A-501, Building no-4, IT Infinity Park, Dindoshi, Malad (E), Mumbai, 400097

GROUP PERSONAL ACCIDENT/ AIR ACCIDENT /DISABILITY CLAIM INTIMATION FORM

(SALARY PACKAGE/PENSION A/Cs)

To be submitted for claiming Personal Accident Insurance (PAI) (death only) /Air Accident Insurance cover (AAI) (death only) within 90 days after date of death of Salary Package Account holder of SBI (Intimation may be advised through Email, Post, Telephone/ Fax) Issuance of this format for intimation of a claim is not to be taken as an admission of liability. Death/Disability due to accident only is covered under the Policy and account should be under Salary Package as on date of accident/death/disability)

 # No column should be left Blank, mark NA if nor applicable.

Policy No. *(A/c State Bank of India)*		*Address:* *Tata AIG General Insurance Co. Ltd* *A-501, Building no-4, IT Infinity Park,* *Dindoshi, Malad (E)* *Mumbai,400097* *Phone/Fax No.022-66930000/66699718* *Email Id: vishal.sawant@tataaig.com* *paclaim.support@tataaig.com*
Policy Period	*04 .01.2022 to 03.01.2023*	

1	*Name of Salary/Pension Account holder*												
2	*Address in full*												
3	*a) Date of Accident*												
	b) Time of Accident												
	c) Place of Accident												
	d) Details of Accident												
	e) Date of Death												
4	*Salary Package/Pension Account No.*												
5	*Xpress Credit (PL) Outstanding (if any), for DSP/CAPSP/ICGSP (Death in action against Anti National Activities, Terrorist, Naxalite foreign enemy only*	*Ac No*											
		O/s											
6	*Type of Salary Package/Pension Account (Tick the appropriate one)*		*CSP/DSP/CAPSP/ICGSP/SGSP/CGSP/PSP/RSP/SUSP/ Pensioner (DSP/CAPSP/ICGSP)*										
7	*Variant of Salary Package A/c (tick the appropriate box)*		*Silver* ☐ *Gold* ☐ *Diamond* ☐ *Platinum* ☐										

8	*Name of Organization for DSP/CAPSP/ICGSP*	*Army / Air Force / Navy / Indian Coast Guard/ Assam Rifle / Rashtriya Rifle / BRO (GREF) / BSF / CRPF / CISF / ITBP / SSB / NSG/RPF/ NDRF/SPG*
		Unit Address:
		Contact Detail *Landline:* *Mobile No:*
9	*Name of the organization for others i.e. PSP/CGSP/SGSP/RSP/SUSP/CSP*	*Name of Employer:*
		Department Name:
10	*Personnel/Force/Batch No./ Employee ID number*	
11	*Details of SBI Branch where Salary Account was maintained*	*Branch Name:*
		Branch Code:
		Place:
		State:
12	*Name of Nominee/Joint Account holder in the salary package account [as per Bank's record]*	
13	*Relationship of Nominee with Account Holder*	
14	*Address of the Nominee*	
15	*E Mail ID of Nominee (if available)*	
16	*Contact Number of Nominee (if available)*	

[#Corporate Salary Package (CSP), Defence Salary Package (DSP), Central Armed Police Salary Package (CAPSP), Indian Coast Guard Salary Package (ICGSP), State Government Salary Package (SGSP), Central Government Salary Package (CGSP), Police Salary Package (PSP) and Railway Salary Package (RSP), Start-up Salary Package (SUSP)]

(@ Please tick on the appropriate organization)

Above information are true to the best of my / our knowledge and belief.

Signature of person Intimating Claim ……

Full Name of person Intimating Claim ……

Relationship with Deceased Account Holder ……..

Contact details of Person Intimating Claim
Landline No …….
Mobile No …….
Email ID …….

Annexure 8

Tata AIG General Insurance Co. Ltd.
A-501, Building no-4, IT Infinity Park, Dindoshi, Malad (E), Mumbai, 400097

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. (A/c State Bank of India)		*Address:* *Tata AIG General Insurance Co. Ltd* *A-501, Building no-4, IT Infinity Park,* *Dindoshi, Malad (E)* *Mumbai,400097* *Phone/Fax No.022-66930000/6669 9718* *Email Id: vishal.sawant@tataaig.com* *paclaim.support@tataaig.com*
Policy Period	***04 .01.2022 to 03.01.2023***	

1. Name of the Salary Account Holder	
2. Occupation	
3. Name of the organization in case of DSP / PMSP / ICGSP/PSP	
4. Designation and Force No	
5. Salary Account No. with SBI	
6. Type of Salary Package Account	
7. Name & Code of SBI Branch	
8. Address of the Claimant	
9. Contact No & Email ID of Salary Account Holder	
10. Details of the Accident	
a. Date of accident:	
b. Time of accident:	
c. Place of accident:	

d. Particulars of accident:	
e. 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**	

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 9

Tata AIG General Insurance Co. Ltd.
A-501, Building no-4, IT Infinity Park, Dindoshi, Malad (E), Mumbai, 400097

MEDICAL CERTIFICATE

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

1		**Details of Claimant (Salary Account Holder)**	
	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 are 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 10

(On State Bank's Letter Head)
State Bank of India

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.	:	
2	Address in full (as per Bank records)	:	
3	Date of Accidental	:	
4	Details of Injury/Loss as per Medical Certificate		
4	Name of SBI Bank Branch where the Salary Package Account is maintained	:	
5	Type of Salary Package account	:	
6	Claim amount under Personal Accident/	:	
7	Phone No.	:	
8	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 State Bank of India,

Signature of Branch Manager
Branch Name:
Branch Code:
Branch Stamp