

Claim Form No: _____

EMPLOYEES COMPENSATION INSURANCE POLICY - CLAIM FORM

Issuance of this form does not imply acceptance of the liability

Please submit the completely filled claim form within thirty days from the date of loss along with the relevant claim documents.

*Policy No.			
Period From	DD / MM / YYYY	Period To	DD / MM / YYYY
Date of Registration	DD / MM / YYYY	Area Office Code/ Service Centre Code	
Broker/Agent Name		Code	
Agent Mobile No.		Agent Email ID	
1. *Name of the Insured			
2. *Customer ID		3. Business/Occupation	
4. *Address of the Insured			
Plot No./Flat No.		Building Name	
Road		Area	
City		*Pin Code	
State		*Phone No.	
Aadhaar (UIDAI) No./NID No.		PAN No.	
*E-mail Id			
Profession/Occupation	☐ Business ☐ Profession ☐ Salary ☐ Agricultural Income ☐ Savings ☐ Others		
Monthly Income	☐ Upto ₹ 20,000 ☐ ₹ 20,001 to ₹ 50,000 ☐ ₹ 50,001 to ₹ 1,00,000 ☐ ₹ 1,00,001 and above		
5. Details of the injured person			
a) Name			
b) Local/Permanent Address			
c) Age/Sex			
d) State nature of work for which the injured person was employed			
e) Was the injured person engaged in the occupation when the accident occurred?			
If not, state exactly nature of work done at that time. ☐ Yes ☐ No			

- f) Is the injured person in your direct employment? If so, state the date of appointment. ☐ Yes ☐ No
If not, give name and address of Contractor under whom employed and nature of work entrusted to contractor.
[copy of the last voucher obtained from the injured person for the wages paid to be attached.]

- g) Under what item of the policy is the injured workman covered?

6. Details of accident

- a) Premises at which accident occurred.

- b) Exact occupation of the premises and general nature of work done.

c) Time and date of occurrence of accident: Date: DD / MM / YYYY Time: HH / MM AM/PM

d) Time when reported and by whom: Time: HH / MM AM/PM

e) Time and date when the injured person actually ceased work: Date: DD / MM / YYYY Time: HH / MM AM/PM

- f) Describe how the accident occurred

g) Are you satisfied that the accident occurred in the course of and arising out of employment? ☐ Yes ☐ No

h) Was the injured person under the influence of alcohol or drugs at the time of accident? ☐ Yes ☐ No

i) Was the injured person guilty of misconduct or disobedience to orders or rules? ☐ Yes ☐ No

- j) State whether the accident occurred as a result of negligence on the part of any employee

k) Has the accident been reported to police or inspector of labour? ☐ Yes ☐ No

(A copy of the report to be attached)

7. Details of Loss

- a) Describe nature of injury and part of body affected.

- b) Describe initial treatment offered. If so, When?

State whether the injured person was admitted in hospital ☐ Yes ☐ No

c) How long is the injured person expected to be in hospital?

d) What is the medical opinion on nature and extent of disablement?
 (A copy of the preliminary Medical Report to be attached)

e) How long is the disablement expected to last?
 (A copy of the fitness certificate from attendant doctor to be obtained after returning to work)

f) Do you any other insurance covering the workman against WC, Personal Accident, E. S. I. Scheme?
 If so, give details. ☐ Yes ☐ No

8. Please give any other particulars relevant to the claim

9. Bank Details

Would you like to opt for NEFT payment?

☐ Yes ☐ No

If YES, please enclose a cancelled cheque leaf along with the claim form.

Bank Name

Branch Name

Branch Name

A/C Holder Name as in
 Bank Record

City

State

Account No

IFSC Code

(this is a 11 digit code printed on your cheque leaf)

PEP DECLARATION:

Are you a Politically Exposed Person (PEP)?

☐ Yes ☐ No

If yes, please mention the position held

Is any of your close relation or family member a PEP?

☐ Yes ☐ No

If yes, please mention the name and relation and the position held by such close relative/family member.

I hereby declare that in future if me, any of my close relatives or any of my family member attains a position of PEP then I shall confirm the same to IndusInd General Insurance Co. Ltd as a mandate. I understand that this is a crucial information under the PMLA Rules and AML/CFT Guidelines and shall confirm that the answers given by me is true. In case the company comes to know that this is a misrepresentation and concealment of information then the policy shall be put on hold for scrutiny by the company and I shall be solely responsible for the same.



indusindinsurance.com



022 4890 3009 (Paid)



74004 22200 (WhatsApp)



Note :

"Politically Exposed Persons" (PEPs) shall have the meaning assigned to it under sub clause (db) of clause (1) of Rule 2 of the Prevention of Money Laundering (Maintenance of Records) Rules, 2005."

(db) "Politically Exposed Persons" (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials".

AML Guidelines

1. I/We hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been /will be paid out of proceeds of crime related to any of the offense listed in Prevention of Money Laundering Act,2002.
2. I Understand that the Company has the right to call for document to established sources of funds.
3. The Insurance Company has right to cancel the insurance contract in case I am/have been found guilty by competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India.

Place: _____

Date: _____

Signature of Proposer

GENERAL DECLARATION:

I understand that as per the new AML/CFT Guidelines issued IndusInd General Insurance Co. Ltd will be verifying my details pertaining to KYC and PAN provided at the time of proposal.

I further, do hereby agree and consent that in the case of the event of a mismatch of information provided by me in the proposal form, identification proof, and address proof at the time of issuance of the policy. I request IndusInd General Insurance Company Limited to issue the policy with the details appearing as per my proposal form. I will be solely responsible for any consequences arising out of the difference in detail given by me during the verification of supporting documents provided by me at the time of issuance of the policy or otherwise.

DECLARATION BY INSURED

I/We hereby declare that the statements made by me/ us in this claim form are true to the best of my/ our knowledge and belief.

Date: _____

Place: _____

Signature of Insured/Authorized Signatory

STATEMENT OF WAGES

- (A) If the injured person has been in the Employer's service during a continuous period of more than one month immediately preceding the accident, then the wages that have been paid, or fallen due for payment to him in each month of such period (not exceeding twelve preceding months in all) must be entered in the statement.
- (B) If the injured person has been in the Employer's service for less than one month, the wages paid to another workmen employed on the same kind of work by the Employer, during the twelve months immediately preceding the accident, must be entered in the statement.
- (C) If worker is daily paid employee, give
 - i Daily rate of wages ₹ _____
 - ii Number of days on an average that he/she works in a month _____

Please fill in the Table of wages below as applicable to [A], [B] or [C]

** In column "Absence" give date of going on leave or beginning of period of absence and also of subsequent resumption of work.

Signature of Insured/Authorized Signatory

* Mandatory details to be filled

DOCUMENT CHECK LIST FOR EMPLOYEE COMPENSATION CLAIM SUBMISSION

Sr. No.	Accidental Death Claim Document Type	Yes/ No	Sr. No.	Accidental Injury Claim Document Type	Yes/ No
A.	Duly filled and signed Claim form		I.	PTD (Permanent Total Disability) & PPD (Permanent Partial Disability)	
B.	Attested copy of Attendance Register		A.	Duly filled and signed Claim form	
C.	Attested copy of Wage Register		B.	Attested copy of Attendance Register	
D.	Copy of the Intimation letter sent to WC Commissioner		C.	Attested copy of Wage Register	
E.	Original/Attested copy of Death Certificate		D.	Copy of the Intimation letter sent to WC Commissioner	
F.	Attested copy of Post Mortem Examination report		E.	Detail Incidence report by the Supervisor	
G.	In Case of Accident- Copy of Medico Level Certificate from hospital		F.	Complete treatment record like Discharge summary, Consultation papers with supporting Investigation reports like X-ray/MRI etc.	
H.	Copy of Photo ID proof of Insured person (Employee/ Member ID card)		G.	In Case of Accident- Copy of Medico Level Certificate from hospital	
I.	Attested copy of FIR of local police station or Detailed Police Information note or Inquest Panchnama / Spot Panchnama (if applicable)		H.	Attested copy of FIR of local police station or Detailed Police Information note or Inquest Panchnama / Spot Panchnama (if applicable)	
J.	In case of Hospitalization: Complete treatment record like Discharge summary, Consultation papers with supporting Investigation reports like X-ray/MRI etc.		I.	Disability certificate issued by Senior Medical Officer mentioning the disability percentage.	
K.	Original Cancelled Cheque in CTS 2010 format (Printed account number, IFSC code, Printed name) Mandatory. In case the name is not printed on cheque leaf, scanned copy of 1st page of passbook or the authorized bank statement.		J.	Coloured and clear photograph of Disabled person showing the disability	
L.	For claimed amount above 1 lac self attested copy of PAN Card /Form 60 of Insured is mandatory & for below 1 lac claimed amount copy of Photo identity proof (PAN Card/Form 60, Aadhaar Card, Voter ID etc.) is mandatory		K.	Copy of Photo ID proof of Insured person (Employee/Member Photo ID proof)	
			L.	Original Cancelled Cheque in CTS 201 O format (Printed account number, IFSC code, Printed name) Mandatory. In case the name is not printed on cheque leaf, scanned copy of 1st page of passbook or the authorized bank statement.	
			M.	For claimed amount above 1 lac self attested copy of PAN Card /Form 60 of Insured is mandatory & for below 1 lac claimed amount copy of Photo identity proof (PAN Card/Form 60, Aadhaar Card, Voter ID etc.) is mandatory	

II	TTD (Temporary Total Disability)	Yes/ No
A.	Duly filled and signed Claim form	
B.	Attested copy of Attendance Register	
C.	Attested copy of Wage Register	
D.	Copy of the Intimation letter sent to WC Commissioner	
E.	Detail Incidence report by the Supervisor	
F.	Medical Certificate confirming the Disability period and the probable date to resume duly/service	
G.	Complete treatment record like Discharge summary, Consultation papers with supporting Investigation reports like X-ray/MRI etc.	
H.	In Case of Accident- Copy of Medico Level Certificate from hospital	
I.	Leave Certificate from the Employer mentioning the leave dates	
J.	Copy of Photo ID proof of Insured person (Employee/Member Photo ID proof)	
K.	Original Cancelled Cheque in CTS 2010 format (Printed account number, IFSC code, Printed name) Mandatory. In case the name is not printed on cheque leaf, scanned copy of 1st page of passbook or the authorized bank statement.	
L.	For claimed amount above 1 lac self attested copy of PAN Card /Form 60 of Insured is mandatory & for below 1 lac claimed amount copy of Photo identity proof (PAN Card/Form 60, Aadhaar Card, Voter ID etc.) is mandatory	

Please note the above list is only indicative. Insured/ Claimant may have to submit additional documents/information if required.

RCare Address:

Rcare Health: IndusInd General Insurance, No.1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad - 500081. Email: healthcare@indusindinsurance.com.