

पुणे विद्यापीठ

(८१)

दूरध्वनी क्रमांक २५६०११५४,
२५६०११६०,
२५००३७००
२५००३७०१



गणेशखिंड, पुणे ४११००७

टेलिग्राम 'युनिपुना'
टेलेक्स: १४५७७१९ युनिप इन्
फॅक्स : ०२०- २५६०११५४

संदर्भ क्र. विक्रम/२०११-१२/२०४

दिनांक : २७ ऑगस्ट, २०११

प्रति,
मा. प्राचार्य / मा. संचालक,
सर्व संलग्न महाविद्यालये / मान्यताप्राप्त संस्था.

विषय : २०११-१२ या शैक्षणिक वर्षातील विद्यार्थी सुरक्षा विमा योजनेसंबंधी...

महोदय,

पुणे विद्यापीठ, विद्यार्थी कल्याण मंडळ कार्यालयामार्फत विद्यार्थी सुरक्षा विमा योजना सन १९९२-९३ पासून सुरु करण्यात आली आहे, हे आपणांस ज्ञात आहेच. यासाठी ज्या विद्यार्थ्यांनी महाविद्यालयात/मान्यताप्राप्त संस्थेत प्रवेश घेतला आहे अशा सर्व विद्यार्थ्यांकडून रु. १०/- विमा निधी म्हणून घेण्यात येतो. सन २०१०-११ या शैक्षणिक वर्षामध्ये न्यू इंडिया एशुरन्स कंपनी लिमिटेड या संस्थेशी विद्यापीठाने करार केला होता. शैक्षणिक वर्ष २०११-१२ साठी दि ओरिएण्टल इन्शुरेन्स कम्पनी लि.यांच्याबरोबर विद्यार्थ्यांच्या विमा संरक्षणासंबंधी करार करण्यात आला आहे.

दि ओरिएण्टल इन्शुरेन्स कम्पनी लि. या संस्थेच्या पुणे, अहमदनगर व नाशिक या जिल्हयांमध्ये शाखा आहेत. त्या शाखांचे पत्ते व दूरध्वनी क्रमांक खालीलप्रमाणे आहेत. सदर विमा योजने अंतर्गत दावा दाखल करण्यासाठी महाविद्यालयांनी संबंधीत शाखांशी संपर्क साधावा. (श्री.सुनिल भारद्वाज ९८८१९०००१९, श्री. एम. एस. लोणकर ९८२२०५२८६०)

कार्यालयाचा पत्ता आणि फोन नं.

(पुणे जिल्हयासाठी)

- १) दि ओरिएण्टल इन्शुरेन्स कम्पनी लि.
पुणे कार्यालय
जीवनदर्शन बिल्डिंग, तिसरा मजला
एन. सी. केळकर रोड, नारायणपेठ,
पुणे - ४११ ०३०
फोन नं. (०२०) २४४५६२९४/२४४५६०५४
Mail ID : 161100@orientalinsurance.co.in

(अहमदनगर जिल्हयासाठी)

- २) दि ओरिएण्टल इन्शुरेन्स कम्पनी लि.
अंबर प्लाझा तिसरा मजला,
स्टेशन रोड अहमदनगर — ४१४ ००१
फोन नं. (०२४१) २४५१८२३/२४५१७३७/२४५२१४६
Mail ID : 163300@orientalinsurance.co.in

(नाशिक जिल्हयासाठी)

(डिव्हिजनल ऑफिस : १)

- ३) दि ओरिएण्टल इन्शुरेन्स कम्पनी लि.
पहिला मजला, मर्चंट चेंबर, टिळक पेठ
नाशिक — ४२२ ००१
फोन नं. (०२५३) २५०८२४५/२५०८२४६/२५९८२४४
Mail ID : 161700@orientalinsurance.co.in

(डिव्हिजनल ऑफिस : २)

- दि ओरिएण्टल इन्शुरेन्स कम्पनी लि.
उद्योग भवन आय. टी. आय. सिग्नलजवळ
त्र्यंबकरोड, सातपूर, नाशिक — ४२२ ००७
फोन नं. (०२५३) २३५१५९०/२३५१५६३
Mail ID : 164000@orientalinsurance.co.in

उपरोक्त नमूद केलेल्या विमा योजने अंतर्गत नुकसान भरपाईचा दावा दाखल करण्यासाठी त्या त्या जिल्हयातील कार्यालयाशी संपर्क साधल्यानंतर त्या पत्राची एक प्रत मा. संचालक, विद्यार्थी कल्याण मंडळ, पुणे विद्यापीठ, पुणे — ४११ ००७ यांना पाठवावी. नुकसान भरपाई दावा दाखल करण्यासाठी आवश्यक त्या कागदपत्रांची पूर्तता करणे आवश्यक आहे.

कळावे,

आपला,

सचिव

संचालक,

विद्यार्थी कल्याण मंडळ

सोबत : क्लेम फॉर्मचा विहित नमुना.



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

A GOVT. 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 consequence 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 Gout, 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 influence 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 any disability ? If not please give date of recovery | |
| 10. Any further recovery | |

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

Date _____

Signature _____

Qualification _____

Address _____

Doctor's Seal
or Rubber Stamp

PERSONAL ACCIDENT CLAIM FORM



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

A GOVT. 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 _____ | | Present Age _____ Years | |
| Residence _____ | | Height _____ M. Cms. | |
| Business Address _____ | | Weight at _____ Kgs. | |
| Present Business or Occupation if more one, state all _____ | | | |
| 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) 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 necessarily 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 work 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 falls 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 _____ 200

Signature _____