संदर्भ क्र. विविमं/२०२१–२२/४३८ दिनांक : २९ जून, २०२२.

प्रति,
मा. प्राचार्य/ मा. संचालक/ मा. विभागप्रमुख
सावित्रीबाई फुले पुणे विद्यापीठीशी संलग्नित सर्व महाविद्यालये व मान्यताप्राप्त परिसंस्था,
सावित्रीबाई फुले पुणे विद्यापीठातील सर्व पदवी व पदव्युत्तर विभाग

विषय : २०२२–२३ या शैक्षणिक वर्षातील विद्यार्थी अपघात सुरक्षा विमा योजना.

महोदय/महोदया,

सावित्रीबाई फुले पुणे विद्यापीठ विद्यार्थी विकास मंडळामार्फत विद्यार्थी अपघात सुरक्षा विमा योजना सन १९९२–९३ पासून सुरू करण्यात आली आहे. सध्या ज्या विद्यार्थ्यांनी महाविद्यालयात/मान्यताप्राप्त परिसंस्थेत आणि विद्यापीठ विभागात प्रवेश घेतला आहे अशा सर्व विद्यार्थ्यांकडून या योजनेअंतर्गत रू. १०/– विमा निधी घेण्यात येतो.

शैक्षणिक वर्ष २०२२–२३ साठी (२९ जून २०२२ ते २८ जून २०२३) टाटा एआयजी जनरल इश्युरन्स कंपनी लिमिटेड, ए–५०१, ५ वा मजला, इमारत क्रमांक– ४, इन्फिनिटी पार्क, दिंडोशी, मालाड (पूर्व), मुंबई – ४०० ०९७ यांच्याबरोबर विद्यार्थ्यांच्या अपघाती विमा संरक्षणासंबंधी करार करण्यात आला आहे. या संस्थेचा पत्ता व दूरध्वनी क्रमांक खाली दिला आहे. सदर विमा योजनेअंतर्गत दावा दाखल करण्यासाठी पुणे, अहमदनगर व (केंद्रशासित प्रदेश सिल्वासासह) नाशिक जिल्हयांतील सावित्रीबाई फुले पुणे विद्यापीठाशी संलग्नित महाविद्यालये व मान्यताप्राप्त परिसंस्था व विद्यापीठ विभाग यांनी अधिक माहितीसाठी पुढील क्रमांकावर संपर्क साधावा.

<u>कार्यालयाचा पत्ता आणि दूरध्वनी</u>.
(अपघात विभाग)
टाटा एआयजी जनरल इश्युरन्स कंपनी लिमिटेड,
ए–५०१, ५ वा मजला, इमारत क्रमांक– ४,
इन्फिनिटी पार्क, दिंडोशी, मालाड (पूर्व), मुंबई – ४०० ०९७

Mail ID	:	**general.claims@tataaig.com** vinod5.suryawanshi@tataaig.com
श्री. विनोद सूर्यवंशी	:	9922944025 / 9890564025
Mail ID	:	vinod5.suryawanshi@tataaig.com

विद्यार्थी अपघात विमा सुरक्षा योजनेअंतर्गत मिळणारी रकम व तपशील खालील चौकटीत दिला आहे.

Sr. No.	Particulars of Coverage	Amount of coverage Rs.
01	Accidental Death	**Rs. 1,00,000/-**
02	Loss of two limbs, eyes or one limb and eye.	**Rs. 1,00,000/-**
03	Loss of one limb or one eye.	**Rs. 50,000/-**
04	Permanent Total Disablement from injuries other than Those named above (PTD)	**Rs. 1,00,000/-**
05	Medical expenses arising out of accidental injuries due to Hospitalization for every students	**Rs. 50,000/-**
06	Any one accident Limit	**Rs. 25,00,000/-**

प्रचलित पध्दतीनुसार आंशिक अपंगत्व, कायमचे अपंगत्व, अपघातग्रस्त विद्यार्थ्यांना औषधोपचारासाठी तसेच मृत्यू पावलेल्या विद्यार्थ्यांच्या पालकांना उपरोक्त निर्धारित संपूर्ण भरपाई रक्कम फक्त विमा कंपनीकडून मिळते; त्यासाठी विमा संरक्षण भरपाई दावा दाखल करण्यासाठी आवश्यक त्या सर्व कागदपत्रांची पूर्तता विमा कंपनीस करणे आवश्यक असते.

(विमा कंपनीने विमा संरक्षण दिलेल्या प्रकरणात विमा कंपनी व्यतिरीक्त विद्यापीठाकडून अन्य कोणतेही आर्थिक सहाय्य करण्याची तरतूद शैक्षणिक वर्ष २०१७–१८ पासून रद्द झाल्याचे आपणास ज्ञात असून त्या अनुषंगाने अशा बाबतीत विद्यापीठास स्वतंत्र अर्ज करून विमा संरक्षण भरपाई दावे सादर करू नयेत.)

कळावे, ही विनंती.

सोबत : विमा संरक्षण नुकसान भरपाई दावा अर्ज आणि नियमावली.

(डॉ. संतोष परचुरे)
संचालक,
विद्यार्थी विकास मंडळ

For Accident

Duly filled claim form
1st consultation papers as on date of loss
Copy of discharge card if hospitalised
All follow up treatment / investigation papers
Hard copy of original bills and its payment receipts

For Death

Duly filled claim form
Copy of FIR, Death certificate, Post Mortem Report
Copy of chemical analysis report if any
Complete set of medical records along with death summary if hospitalized
1st earning parent details as per school / college record
CKYC form duly filled by 1st earning parent along with copy of Aadhar card & pan card
Discharge voucher duly filled by 1st earning parent
Copy of cancel cheque of 1st earning parent

Claim Intimation on Mail ID: - **general.claims@tataaig.com**

NOTE:

Please submit the claim documents at the address mentioned below:

TATA AIG GENERAL INSURANCE CO LTD

CLAIMS DEPARTMENT

TATA-AIG General Insurance Company Limited,

A-501,5Th Floor, Bldg No -4,

Infinity Park, Dindoshi,

Malad East –

Mumbai – 400 097

COLLEGE/ INSTITUTION LETTER HEAD

Date :

TO WHOMESOEVER IT MAY CONCERN

This is to certify that Mstr/Mr/Ms._____(Student/Staff)

is/was with our institution/school/college since (First Date of Joining)_____

currently studying in the Grade/Division_____(In Case of staff,

please state the designation)

We hereby confirm that first earning parent of the student as per the institution/school/ college

records is_____.

Authorized Signatory & Stamp of the Institution/School/College

P.S: The name of the Institution/School/College should be as per the name available in the PolicyCertificate/Schedule.

TATA-AIG GENERAL INSURANCE COMPANY LTD

Address: 4th Floor, AHURA CENTRE,
82, MAHAKALI CAVES ROAD
ANDHERI EAST, MUMBAI 400093

GROUP PERSONAL ACCIDENT CLAIM FORM

IMPORTANT

1. **Issuance of this form is not an admission of Liability or a waiver of the terms, conditions and exceptions of the insurance contract.**
2. **No claim will be admitted without a Medical Report as per format to be obtained at claimant's expense.**
3. **We may call for additional information/ documents as relevant.**

Policy No. 0239484308 **Claim No. ----------**

1. **COMPANY DETAILS:**
   Name of the Organization _____
   Address _____
   _____ **State**_____ **Pin**_____

   Contact Persons Name_____ **Phone No**_____
   Fax No._____ **E-Mail Id** _____

2. **INSURED PERSONS DETAILS**
   NAME _____
   Address _____
   _____STATE_____PIN _____
   Phone No. _____Fax No._____E - Mail id. _____
   Age _____SEX _____

3. **DETAILS OF ACCIDENT**
   Time and Date _____
   Place and Location (Full Address)- _____
   Please describe in detail how the incident took place_____
   Please describe details of injury sustained _____
   Specify the injured parts of body _____

4. **WITNESSES**

   1) Name ___ 2) Name _____
   Address _____ Address _____

   _____ _____
   _____ _____

5. **TREATMENT DETAILS**

- Treating Doctor
  Name _____
  Address _____
  Phone _____
  Registration No ----------

- Family Doctor
  Name ----------
  Address ----------
  Phone ----------
  Registration No. ----------

- Hospital(s) if hospitalised
  Name ----------
  Address ----------
  Phone No ----------

6. **AMOUNT OF CLAIM** (Subject to Policy coverage)
   A Total Temporary Disablement Amount (Rs.)_____(Rs._____per week for_____weeks____days)

   B Medical Expenses Amount (Rs.)_____

   C Accident Death Amount (Rs.)_____

   D Permanent/Partial Disability Amount (Rs.)_____

7. **PAST HISTORY**
   A Have you made any claims in the PAST? YES/NO

   B If YES, please give the following details:

Sr. No	Name of Insurance Co.	Policy No.	Accident Details	Amount
1.				
2.				

1. **Have the Police Authorities been informed of this accident?** YES/ NO If Yes, FIR/ Case Diary No.----------

Employment details:
Designation/ Grade/ Occupation: _____Nature of Duty_____Date of joining_____

8. **LEAVE PARTICULARS**
   The Employee was on leave from_____to_____.

   No. of days _____

9. **SALARY DETAILS**
   Month & Year _____
   Basic Pay _____
   Dearness Allowance _____
   Other Allowance _____
   Gross Salary _____

10. **Please put a [√] mark against the documents being sent:**

Attending Doctor's Report [ ],Disability from the Doctor [ ], Fitness Certificate from the Doctor [ ], X-ray Films [ ], X-ray reports [ ],

Original Admission/discharge card [ ],Original Medical Bills / receipts [ ], Employers Leave Certificate [ ], Latest Salary Certificate [ ].

I hereby declare that I have suffered injuries as described above and all the details given are ABSOLUTELY **TRUE AND CORRECT**.I hereby agree to forfeit all my rights to compensation if any of the foregoing facts and /or details are found to be false or incorrect, further authorise the hospital ,doctor diagnostic laboratory,organisation,establishment or any other body or person dealt with in the course of this claim to give any information or document sought for by the Insurance Company.

Signature of Insured Person/ Claimant

Signature of Authorized Person
Company Seal

Date:
Place:

ATTENDING PHYSICIAN'S STATEMENT

PLEASE ANSWER ALL QUESTIONS

1 Name of Injured Person: .....
Age ----------
2 Address .....
.....
.....

3 Nature of the Accident and Details of Injuries Sustained .....
(Specify the part of the body) .....

4 Does the Cause of Accident as stated by the Claimant tally with the Injuries noticed by you? ----------

5 Are the injuries solely due to the accident or traceable to any previous injuries/ disease/ infirmities? ----------
.....

6 Was the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition. .....

7 Was the Claimant hospitalized? If so for what period? .....

8 What treatment was given and Operations performed? .....

9 Give dates of treatment: Home: From---------- ---- To ----------
Clinic/Hospital :From..... To.....

10 Was he under the influence of intoxicants or drugs at the time of accident?----------
(If yes, what action taken?)

11 Are you his usual medical Attendant? YES / NO
If you have treated him for any previous illness or injury, Please give details: ----------
.....

12 Have other Doctors been in Attendance or Consultation? If yes, Please give details. ----------
.....

13 Has this accident been reported to the Police Authorities? If yes, Case No: ---------- Police Station ----------

14 Is this claimant Totally Disabled from each and every occupation? ----------

15(a) How long was or will the claimant be totally disabled from current occupation? From----- ---------- To----------
(b) Estimated date of return to Work. .....

16 What is the Prognosis? .....

This information is true to the best of my knowledge.

Doctor's Signature **Date:** **Regn No:**

Doctors Name:
Address and Phone No.

फक्त मृत्यू दावा दाखल करतेवेळी सदर अर्जाचा वापर करावा.

CENTRAL KYC REGISTRY | Know Your Customer (KYC) Application Form | Individual

Important Instructions:

A) Fields marked with '*' are mandatory fields.
B) Please fill the form in English and in BLOCK letters.
C) Please fill the date in DD-MM-YYYY format.
D) Please read section wise detailed guidelines / instructions at the end.
E) List of State / U.T code as per Indian Motor Vehicle Act, 1988 is available at the end.
F) List of two character ISO 3166 country codes is available at the end.
G) KYC number of applicant is mandatory for update application.
H) For particular section update, please tick (√) in the box available before the section number and strike off the sections not required to be updated.

For office use only
(To be filled by financial institution)

Application Type* ☐ New ☐ Update
KYC Number *(Mandatory for KYC update request)*
Account Type* ☐ Normal ☐ Simplified (for low risk customers) ☐ Small

☐ 1. PERSONAL DETAILS (Please refer instruction **A** at the end)

	Prefix	First Name	Middle Name	Last Name
☐ Name* (Same as ID proof)				
Maiden Name (If any*)				
Father / Spouse Name*				
Mother Name*				

Date of Birth* D D – M M – Y Y Y Y

PHOTO

Gender* ☐ M- Male ☐ F- Female ☐ T-Transgender

Marital Status* ☐ Married ☐ Unmarried ☐ Others

Citizenship* ☐ IN- Indian ☐ Others (ISO 3166 Country Code)

Residential Status* ☐ Resident Individual ☐ Non Resident Indian ☐ Foreign National ☐ Person of Indian Origin

Occupation Type* ☐ S-Service (☐ Private Sector ☐ Public Sector ☐ Government Sector) ☐ O-Others (☐ Professional ☐ Self Employed ☐ Retired ☐ Housewife ☐ Student) ☐ B-Business ☐ X- Not Categorised

Signature / Thumb Impression

☐ 2. TICK IF APPLICABLE ☐ RESIDENCE FOR TAX PURPOSES IN JURISDICTION(S) OUTSIDE INDIA (Please refer instruction **B** at the end)

ADDITIONAL DETAILS REQUIRED* (Mandatory only if section 2 is ticked)

ISO 3166 Country Code of Jurisdiction of Residence*

Tax Identification Number or equivalent (If issued by jurisdiction)*

Place / City of Birth*

ISO 3166 Country Code of Birth*

☐ 3. PROOF OF IDENTITY (PoI)* (Please refer instruction **C** at the end)

(Certified copy of <u>any one</u> of the following Proof of Identity[PoI] needs to be submitted)

☐ A- Passport Number — Passport Expiry Date D D – M M – Y Y Y Y
☐ B- Voter ID Card
☐ C- PAN Card
☐ D- Driving Licence — Driving Licence Expiry Date D D – M M – Y Y Y Y
☐ E- UID (Aadhaar)
☐ F- NREGA Job Card
☐ Z- Others (any document notified by the central government) — Identification Number
☐ S- Simplified Measures Account - Document Type code — Identification Number

4. PROOF OF ADDRESS (PoA)*

☐ 4.1 CURRENT / PERMANENT / OVERSEAS ADDRESS DETAILS (Please see instruction **D** at the end)

(Certified copy of <u>any one</u> of the following Proof of Address [PoA] needs to be submitted)

Address Type* ☐ Residential / Business ☐ Residential ☐ Business ☐ Registered Office ☐ Unspecified

Proof of Address* ☐ Passport ☐ Driving Licence ☐ UID (Aadhaar) ☐ Voter Identity Card ☐ NREGA Job Card ☐ Others (please specify) ☐ Simplified Measures Account - Document Type code

Address

Line 1*
Line 2
Line 3
City / Town / Village*
District* Pin / Post Code* State / U.T Code* ISO 3166 Country Code*

☐ 4.2 CORRESPONDENCE / LOCAL ADDRESS DETAILS * (Please see instruction **E** at the end)

☐ Same as Current / Permanent / Overseas Address details (In case of multiple correspondence / local addresses, please fill '**Annexure A1**')

Line 1*
Line 2
Line 3
City / Town / Village*
District*
Pin / Post Code*
State / U.T Code*
ISO 3166 Country Code*

☐ 4.3 ADDRESS IN THE JURISDICTION DETAILS WHERE APPLICANT IS RESIDENT OUTSIDE INDIA FOR TAX PURPOSES* (Applicable if section 2 is ticked)

☐ Same as Current / Permanent / Overseas Address details ☐ Same as Correspondence / Local Address details

Line 1*
Line 2
Line 3
City / Town / Village*
State*
ZIP / Post Code*
ISO 3166 Country Code*

☐ 5. CONTACT DETAILS (All communications will be sent on provided Mobile no. / Email-ID) (Please refer instruction **F** at the end)

Tel. (Off) – Tel. (Res) – Mobile –

FAX – Email ID

☐ 6. DETAILS OF RELATED PERSON (In case of additional related persons, please fill 'Annexure B1') (please refer instruction **G** at the end)

☐ Addition of Related Person ☐ Deletion of Related Person KYC Number of Related Person (if available*)

Related Person Type* ☐ Guardian of Minor ☐ Assignee ☐ Authorized Representative

Name* Prefix First Name Middle Name Last Name

(If KYC number and name are provided, below details of section 6 are optional)

PROOF OF IDENTITY [PoI] OF RELATED PERSON* (Please see instruction (**H**) at the end)

☐ A- Passport Number Passport Expiry Date D D – M M – Y Y Y Y

☐ B- Voter ID Card

☐ C- PAN Card

☐ D- Driving Licence Driving Licence Expiry Date D D – M M – Y Y Y Y

☐ E- UID (Aadhaar)

☐ F- NREGA Job Card

☐ Z- Others (any document notified by the central government) Identification Number

☐ S- Simplified Measures Account - Document Type code Identification Number

☐ 7. REMARKS (If any)

8. APPLICANT DECLARATION

- I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform you of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be held liable for it.
- I hereby consent to receiving information from Central KYC Registry through SMS/Email on the above registered number/email address.

Date : D D – M M – Y Y Y Y Place :

[Signature / Thumb Impression]

Signature / Thumb Impression of Applicant

9. ATTESTATION / FOR OFFICE USE ONLY

Documents Received ☐ Certified Copies

KYC VERIFICATION CARRIED OUT BY

Date D D – M M – Y Y Y Y
Emp. Name
Emp. Code
Emp. Designation
Emp. Branch

[Employee Signature]

INSTITUTION DETAILS

Name
Code

[Institution Stamp]