ICICI Lombard

GENERAL INSURANCE

## STUDENT SAFETY INSURANCE

Allahabad Agricultural Institute Deemed University, a University of International Repute with a student base from within and outside the country offers its students an insurance cover - under the Student Safety Insurance Policy of the ICICI Lombard General Insurance Company Ltd., to ensure smooth and continuous education in spite of unnatural and unforeseen circumstances as given herein under three insurance covers.

1. **PERSONAL ACCIDENT INSURANCE OF PARENT (PRINCIPAL BREAD WINNER)**
   In the unfortunate event of unnatural death (due to the effect of external forces, eg., accident, burning, murder, drowning, mauling by wild animals, electrocution, snake bite, fighting, wrong medication, consumption of poison, etc.,. and not caused due to illness/disease) of the named bread-winner of the family (father/mother or guardian if not survived by a father or mother at the time of admission), the dependent (student) shall be paid an amount of Rs.1.00 Lac.
2. **CONTINUING EDUCATION FUNDS COVER**
   Arising out of the same event, as stated above in Point No 1, in the event of unnatural death or accidental permanent total disablement of the named bread-winner of the family, leading to the loss of earning, this cover shall pay a lump-sum to the Institute (AAIDU) towards the costs of continued education for the remaining years for the course the student is pursuing at the time of such mishap and continues to pursue after the accident. These costs shall include the Professional Education Fee, and Hostel Fee in the case of students residing in the Hostel. Maximum limit will be Rs.3.50 Lacs per student.
3. **PERSONAL ACCIDENT COVER**
   All students for whom the premium has been paid, shall be covered against death, Permanent Total Disablement (PTD) and Permanent Partial Disablement (PPD) arising out of a unnatural death, to the extent of Rs.2.0 Lacs per student. The benefits shall be as under:-

| Cover | Liability |
|---|---|
| Death /Permanent Total Disablement | Rs.2.0 Lacs |
| Permanent Partial Disablement (Loss of One Limb or One eye etc.,.) | As certified by the Doctor; 50% of the sum insured for PA cover for the student. |

4. **MEDICAL TREATMENT COVER**
   All students shall be covered for medical treatment in a hospital arising out of a disease/illness/accident up to a limit of Rs. 25,000.00 per student per annum & the limit for each illness /accident shall be Rs. 5,000.00.
   If immediate availability of funds for taking treatment is a problem then, ICICI Lombard GIC Ltd., can provide cashless facility in over 200 hospitals in the state of U.P.

## PROCESS OF CLAIM

### Personal Accident re-imbursement

In case of unnatural death of a Student/Named Bread Winner of the family a written intimation of Death within 60 days from the date of incidence as well as the following documents are required to be submitted with the University:-

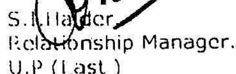
1. FIR registered at the nearest Police Station. (photocopy)
2. Post Mortem Report. (photocopy)
3. Duly Filled Claim Form. (available in the Finance & Accounts Office - AAIDU and on the website www.aaidu.org )
4. Copy of Identity card of the student.
5. Death certificate, wherever necessary/applicable. (photocopy)
6. Address of permanent residence with PIN CODE / Telephone / Cell Numbers
7. Address of residence with PIN CODE while studying at AAIDU.

### MEDICAL RE-IMBURSEMENT

1. Duly Filled Claim Form. (available in the Finance & Accounts Office -- AAIDU and on the website www.aaidu.org )
2. Medical Bills & Treatment Bills. (photocopy)
3. Discharge vouchers & other treatment papers. (photocopy)
4. Address of permanent residence with PIN CODE / Telephone / Cell Numbers .
5. Address of residence with PIN CODE while studying at AAIDU.

Thanking you .

Yours faithfully.



S.I. Halder,
Relationship Manager.
U.P (East )

**ICICI Lombard General Insurance Company Ltd.**

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AA 0021284 / 07

## ICICI LOMBARD GENERAL INSURANCE COMPANY LIMITED

## STUDENT SAFETY INSURANCE

## ALLAHABAD AGRICULTURAL INSTITUTE- DEEMED UNIVERSITY

## CLAIM FROM FOR PERSONAL ACCIDENT INSURANCE

**(The issue of this form is not to be taken as an Admission of Liability)**

| Office Address: | Cover Note / Policy No. :<br>Period of Insurance :<br>Date of Accident :<br>Claim Number : |
|---|---|

**PLEASE ANSWER ALL QUESTIONS FULLY**

| **1.** | **DETAILS OF INSURED** | |
|---|---|---|
| (i) | Name | (i) |
| (ii) | Address for correspondence | (ii) |
| (iii) | Contract Number | (iii) |
| 2. | | |
| (i) | Name of injured person | (i) |
| (ii) | Address of injured person | (ii) |
| (iii) | Age | (iii) |
| (iv) | Date & time of injury | (iv) |
| (v) | Place of injury | (v) |
| (vi) | Details of the accident | (vi) |
| (vii) | Whether reported to Police. | (vii) Yes/ No |
| (viii) | If yes then name and address of Police Station | (viii) |
| 3. | Were you moved to hospital immediately after the accident?<br>If Yes, Name & address of the hospital | Yes/ No |
| 4. | Do you have any other personal Accident Policy?<br>If yes, Please give: | |

| | | |
|---|---|---|
| i) | Name of the Insurance company | |
| ii) | Address of the issuing office | |
| iii) | Policy No | |
| iv) | Period | i) |
| | | ii) |
| | | iii) |
| | | iv) |

I hereby agree, affirm and declare that:

(a) The statements/ information given/ stated by me in this claim form are true, correct and complete.

(b) No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.

(c) If have given/ made any false or fraudulent statement/ information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I shall not be entitled to all/ any rights to recover thereunder in respect of any or all claims, past, present or future.

(d) The receipt of this claim form/ other supporting/ related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/ additional information in respect of the claim.

Place

Date Signature of the Injured Person

**(To be filled in by the Employer/ Insured)**

| | | |
|---|---|---|
| 1. | Was the injured person in respect of whom claims being made absent from work?<br><br>If so, please furnish the details of such absence. | Yes/ No |

I/ We hereby declare that the particulars made by the injured person in the claim from are true to the best of our knowledge and belief.

Place :

Date: Signature of the Insured

| SECTION II (TO BE COMPLETED BY HOSPITAL AUTHORITIES) | | |
|---|---|---|
| 1. | Name and address of the hospital | |
| 2. | Date of admission<br>(As in patient/ out patient/ emergency case) | |
| 3. | Date of discharge | |
| 4. (i)<br><br>(ii) | Nature of Injury<br><br>Particulars of treatment | |
| 5. (i)<br><br>(ii) | Has the accident resulted into loss of hand/s or foot/ feet or eye/s or permanent disability of any other type which may prevent the insured from engaging in or being occupied with or giving attention to any employment or occupation whatsoever ?<br><br>If yes, please give details | Yes/ No |

Signature of the competent Authority of
Hospital/ Nursing Home

Date:

Name:

Office Seal of the Hospital:

Designation:

| SECTION III (TO BE COMPLETED BY NOMINEE IN THE EVENT OF INSURED'S DEATH) | | |
|---|---|---|
| 1. | Details of Nominee | |
| (i) | Full Name | |
| (ii) | Address | |
| (iii) | Age | |
| (iv) | Relationship with the decease | |
| Date:<br>Place: | | Signature of the Nominee |
| 1. | Please attach the following documents:- | |
| (i) | Death Certificate | |
| (ii) | Post Mortem Report | |
| (iii) | Original Policy document with receipt | |

Declaration to be signed by the Insured/ claimant or by the Nominee (in the event of Insured's death)

I/ WE HEREBY DECLARE and warrant the truth of the foregoing particulars in every respect. I/ We agree that if I/ We have made or shall make false or untrue statement, suppression or concealment, my/ out right to compensation shall be forfeited.

I/ we also here by declare that I am/ we are accepting the amount in full discharge of your obligations under the policy to the Insured Person and/ or his/ her legal heirs. I/ we will hold you indemnified in the event of any claim under this policy being made against you by any other person or persons.

**Date:**

**Place:** **Signature of the Nominee**

# ICICI LOMBARD GENERAL INSURANCE COMPANY LIMITED

Regd. Office: ICICI Towers, Bandra Kurla Complex, Bandra (East), Mumbai – 400 051

## CLAIM FORM FOR GROUP MEDICLAIM POLICY

(The issue of this form is not to be taken as an Admission of Liability)
Please give the following information correctly and completely.

**Claim No.** ______________________

| | | |
|---|---|---|
| **1.** | Name of the Insured : | |
| (i) | Name of the Insured Employee: | |
| (ii) | Salary Roll No.: | |
| (iii) | E-mail id: | |
| (iv) | Policy No.: | |
| **2.** | Details of the Insured Person in respect of whom claim is made: | |
| (i) | If family member, name & relationship to the insured employee: | |
| (ii) | Present completed age: | |
| (iii) | Occupation: | |
| (iv) | Residential address: | |
| **3.** | Nature of disease / illness contracted or injury suffered: | |
| **4.** | Date of injury sustained or disease / illness first detected: | |
| **5.** (i) | Name and address of the hospital / Nursing Home / Clinic: | |
| (ii) | Date of admission: | |
| (iii) | Date of discharge: | |

| | | |
|---|---|---|
| **6.** (i) | Amount of Pre and Post Hospitalisation Expenses incurred: | |
| (ii) | Total Amount Claimed: | |
| **7.** | If the claim is for domiciliary hospitalization, please indicate: | |
| (i) | Date of commencement of treatment: | |
| (ii) | Date of completion of treatment: | |
| (iii) | Name & address of attending Medical Practitioner: | |
| (iv) | Practitioner Qualification: | |
| (v) | Telephone No.: | |

**In support of the above claim, I enclose following documents {Please indicate by (✓)}**

1. Bills, Receipt and Discharge Certificate / card from the Hospital/Nursing Home.
2. Cash memos from the Hospital / Chemist(s), supported by the proper prescription.
3. Receipt and Pathological test reports from a Pathologist supported by the note from the attending Medical Practitioner / Surgeon demanding such Pathological tests.
4. Surgeons certificate stating nature of operation performed and surgeon's bill and receipt.
5. Attending Doctor's / Consultant's / Specialist's / Anesthetist's bill and receipt and certificate regarding diagnosis, whichever is prescribed & thereby expenses incurred

**Declaration**

I hereby agree, affirm and declare that:

(a) The statements/information given/stated by me/us in this claim form are true, correct and complete.

(b) No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.

(c) If I have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I shall not be entitled to all/any rights to recover there under in respect of any or all claims, past, present or future.

(d) The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.

**In case of Maternity Benefits Extension:**

I hereby declare that at the time of delivery covered by this claim, I did not have more than two living children. I hereby warrant the truth of foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statements, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited notwithstanding any other action that the Company may take against me under the rules. I further declare that in respect of the above treatment, no benefits are admissible under any other Medical Scheme or insurance.

**In case of Reimbursement of Cost of Health Check-Up Extension**

I confirm that no claim has been made by my family members or me for the past 4 policy periods nor any claim is proposed to be lodged for the said period.

Place:

Date: **Signature of Insured Employee**

**Important:**

Since it is a pre-requisite for admission of claims under the policy that the Hospital / Nursing Home / Clinic where the Insured Person was admitted, is registered with Local Authorities, it is necessary for the claimant to ensure that the Hospital / Nursing Home / Clinic indicates the same on the Bill-cum-Receipt issued by them.

(To be filled in by the Employer/Insured)

Was the injured person in respect of whom claims being made absent from work?

If so, please furnish the details of such absence

Yes/No

I / We hereby declare that the particulars made by the injured person in the claim from are true to the best of our knowledge and belief.

Place :

Date : **Signature of the Insured**