



**04. If hospitalized due to the accident, details about it**

- 4.1 Hospital where treated :- .....
- 4.2 Period of hospital stay :- .....
- 4.3 Period of leave prescribed by the doctor :- .....
- 4.4 Damages suffered as a result of the accident :- .....

**05. Bank Account details (The Bank Account should be the account to which applicant's monthly salary it is credited, a certified copy of the pass book should be attached and submitted.)**

- 5.1 Your name appeared in the Bank Account :- .....
- 5.2 Account Number :- 

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- 5.3 Name of the Bank :- ..... Bank Branch :- .....

**06. Certificate of the Accountant of the Institute**

File Number assigned to your institute by the National Insurance Trust Fund :- 

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 (File Number)

I hereby certify that the monthly salary of the above mentioned Mr./ Mrs. .... is credited to the Account No. .... at the Bank Branch of ..... of the Bank .....

.....  
Date  
Signature :- .....  
Name :- .....  
Designation :- .....  
(Official Seal is Compulsory)

**07. Certificate of the Head of the Institute**

I hereby submit the insurance claim of the above mentioned Mr./Ms. .... for necessary purposes. I certify that the above information is true and correct as per his/her personal file.

I hereby certify that the monthly Agrahara Insurance Premium of Rs: ..... related to the month of ..... of the year 20...., the month before the accident occurred, has been credited to the Account No. 033-1002-3246-7951 of Queen's Branch of the People's Bank of the National Insurance Trust Fund by Cheques ( Cheque No.....)/ SLIPS and included it to the total amount of Rs: .....

- 7.1 The officer has reported the accident to this office on .....
- 7.2 The date reported for duty after accident :- .....
- 7.3 Period of leave recommended by doctor is from ..... to .....
- 7.4 If the officer concerned is unable to report to service after accident, remarks on it.

.....  
Date  
Signature :- .....  
Name :- .....  
Designation :- .....  
(Official Seal is Compulsory)

# Medical Certificate

**In respect of the Accident pertaining to .....**  
**I hereby certify that I have examined the above named who was injured in the Accident described overleaf and that the injuries were as follows.**

1. Regions Injured?  
.....  
.....  
(If limb state whether right or left)
2. Nature and extent of injuries?  
.....  
.....
3. (a) State as fully as possible the cause of the accident?  
.....  
.....  
(b) Is the appearance of the injury consistent there with?  
.....  
.....
4. Is there any connection between the present disablement and any disease or previous disability, If so what?  
.....
5. Is surgical interference necessary or likely to become so?  
.....  
.....
6. (a) Is the patient now or was he at the time of the accident, subject to or suffering from any illness or disease irrespective of the injury?  
.....  
.....  
(b) If so state the nature there of?  
.....  
(c) The probable duration thereof and the extent to which it has affected the patient's recovery?  
.....  
.....
7. Will the injury in your opinion, result in permanent disablement?  
.....  
.....
8. (a) Are the injuries such that will totally disable the patient from engaging in or giving attention to his/her profession or occupation?  
.....  
.....  
(b) Are the injuries such that will partially disable the patient from engaging in or giving attention to his/her profession or occupation?  
.....
9. upon what date did you first see and examine the insured after the accident described here in?  
.....  
.....

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## **N:B :- Temporary Total Disablement (Medical Leave)**

(Arises when the claimant is rendered completely incapable of attending to any part of his ordinary profession, business or occupation) I further certify that he/she has been totally disabled by the above injuries received due to the accident from the ..... day of ..... to the ..... day of ..... and that he/she is likely to be disabled for .....

## **Temporary partial disablement (Light Duty)**

9.1 I further certify that he/she is partially disabled by the above injuries received due to the accident from the ..... day of ..... and is unable to perform his/her normal duties as specified in the form perfected by the employer and submitted by the claimant and that he/she is likely to be so disabled for ..... from .....

**Signed :-** .....

**Designation :-** .....

**Address :-** .....

.....

## **Instructions to Fill the Application**

- 1.** The insured only is covered by Accident insurance cover.
- 2.** The claim application must be received to the National Insurance Trust Fund within 90 days of reporting back to work after the accident.
- 3.** It is essential to write the National Identity Card Number clearly and correctly in every correspondence you send to us.
- 4.** Copies of documents should be certified by the head of the institution whenever they are submitted.
- 5.** The medical certificates attached to the application should be completed by the doctor who treated you.
- 6.** The following documents should be submitted along with the duly completed application.
  - 6.1** Salary details of three months prior to the accident certified by the Accountant.
  - 6.2** Accountant's certificate to the effect that the insurance premiums have been paid continuously from three months before the accident occurred till the date of the accident should be submitted along with the cheque details for computer verification. (This may vary depending on the date of obtaining the insurance cover)
  - 6.3** Medical certificates approving leave.
  - 6.4** Medical Board Report (if more than three months leave)
  - 6.5** Other medical and police reports that can prove the accident
  - 6.6** Copy of driving license certified by Head of Institution. (If the driver is the insured in a vehicle accident)
  - 6.7** Letter of the head of the institute stating the date of reporting to work after the accident.
  - 6.8** Copies of the diagnosis cards related to the period of hospitalization certified by the head of the institute should be forwarded
  - 6.9** Mention the National Identity Card number while perfecting the deficiencies of the claim applications after submitting it.
- 7.** If unable to report to work after the accident, the application should be forwarded within 90 days from the date of issuance of the report of the medical board.