The Oriental Insurance Company Ltd.
Divisional Office No.-10, 101 LSC, H-Block Market (Lal Market)
Vikaspuri, New Delhi-110018
Phones : 28544982, 28544983, 28544984
Fax: 28544981, E-Mail : 212200do10nd@orientalinsurance.co.in

CHECK LIST FOR SUBMISSION OF DOCUMENTS: (Please √ the appropriate box)

1.CLAIM INTIMATION: YES ☐ NO ☐

2.CLAIM FORM YES ☐ NO ☐

3. F.I.R. YES ☐ NO ☐
(Original or duly attested Copy. In case of F.I.R. in local language-Duly attested translated copy in English along with the original copy)

4. FINAL POLICE REPORT / CHARGE SHEET/ INQUEST REPORT: YES ☐ NO ☐
(Original or duly attested Copy. In case of Police Report in local language-Duly attested translated copy in English along with the original copy)
This is must in case of murder, personal enemity, family feud cases

5. POST MORTEM REPORT: YES ☐ NO ☐
(Original or duly attested Copy, In case of P.M.R. in local language-Duly attested translated copy in English along with the original copy)

6. DEATH CERTIFICATE: YES ☐ NO ☐
(Original Copy. In case of Death Certificate in local language-Duly attested translated copy in English along with the original)

7. LEGAL HEIR CERTIFICATE: YES ☐ NO ☐

8. PHOTO COPY OF MEMBERSHIP ADMISSION REGISTER: YES ☐ NO ☐
(Date of Membership should be duly incorporated)

9. INDEMNITY BOND: YES ☐ NO ☐
(In Missing cases only)

10. ANY OTHER SUPPORTING DOCUMENT: YES ☐ NO ☐
(e.g. Medical papers in case of continued treatment, Statement of witnesses. Any resolution passed by the Cooperative body etc.. Driving License if the deceased was driving the vehicle which met with the accident)

If answer to 10 is Yes give details: i

From:(Name& Address of the sponsoring Agency)

Annexure-I

_____

_____

_____

_____

To:
The Managing Director
National Federation of Fishermen's Co-operatives Ltd.
7,Sarita Vihar Institutional Area
New Delhi-110044

Subject: **Claim Intimation under Group Janta Personal Accident Policy A/C**_____

This is to inform you that Sri/Smt/Km._____of village_____

P.O._____District_____State_____ ___. who was insured

under the Fishermen Accident Insurance as a member of (*Name & full address of the society*)

_____

_____

_____

died/disabled on account of accident on_____.

We are enclosing the claim form along with the necessary enclosures as per the checklist duly completed and signed by the certifying authority who was nominated by the State Government.

We would request you that a sum of Rs _____ being the capital sum insured under the policy may be kindly sent through a crossed cheque in favour of Sri/Smt./Km. _____ __(insured person/nominee of the insured person) for disbursement as per the provision of the rules framed in this behalf.

The original receipt of the amount disbursed to the insured/nominee would be sent to you within a fortnight of its receipt.

Thanking you

Yours faithfully

(Signature)

Name_____

Designation_____

Seal

Date:

The Oriental Insurance Company Ltd.
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Annexure-2

J.P.A. CLAIM FORM
(FOR FISHERMEN WHO ARE THE MEMBERS OF FISHCOPFED)

Policy No. / Endorsement No. _____ Period _____

1. Name of the Society with address _____

2. Name & Address of the Fisherman _____

3. Age of the Deceased / Disabled _____yrs.

4. Date & Time of Accident_____5. Date of Death _____

6. Cause Of Death_____

7. Membership No. _____8. Dt. of Membership _____

9. Total Membership of the Society as on Date (Date_____ _____

10. Total Membership up to the age of 65 years proposed for Insurance _____

11 Name of the Nominee & Address_____

10. Relationship of the Nominee with the deceased _____

We hereby declare that we have checked up the records and certify that the deceased/disabled person was/is a member of the society and was insured under the scheme on the date of accident and was/is duly covered under the Policy. We further declare that the Insured member was free from any physical disability prior to this accident

Signature of Certifying Authority _____

Name _____
Designation & Address _____(Affix Official Stamp)

Annexure-3

The Oriental Insurance Company Ltd.
Divisional Office No.-10, 101 LSC, H-Block Market (Lal Market)
Vikaspuri, New Delhi-110018
Phones : 28544982, 28544983, 28544984
Fax: 28544981, E-Mail : 212200do10nd@orientalinsurance.co.in

CLAIM DISBURSEMENT VOUCHER

Received from The Oriental Insurance Co. Ltd. a sum of Rs. _____ only

(Rs_____ _____) towards full and final settlement of

Claim No. _____ under Policy No,_____ arising out of accident on

_____

(Signature/L.T.I. of Insured Member/Nominee on a Revenue Stamp)

Signature/L.T.I. Attested of Insured Member/Nominee

(Signature)
Name & Address
of the Certifying Authority_____

(Affix official Stamp) _____

_____

ANNEXUE 4

NATIONAL FEDERATION OF FISHERMEN'S COOPERATIAVES LTD.

7, Sarita Vihar Institutional Area, New Delhi-110044.

ACCIDENT INSURANCE MEDICAL REPORT

(This form is to be completed and signed by a Medical Attendant)

1.	Name and Address of Injured Person	
2.	Describe nature and extent of injuries	
3.	Cause of the accident so far As is known to you	
4. (a)	When did you first attend on the injured person following the accident?	(a)
(b)	Are you still attending on him?	(b)
4.	Are you his usual Medial Attendant? If you have Treated him for any previous illness or injury, Please give details.	
5. (a)	Are his injuries	(a)
(i)	solely due to the accident or	(i)
(ii)	traceable to any disease, infirmity previous injuries or any other cause?	(ii)
(b)	Is the Injured person suffering from any disease or Injury (apart from his injury) which directly or indirectly?	(b)
(i)	may have contributed to the accident,	(i)
	or	
(ii)	is likely to retard his recovery from the injuries	(ii)
(iii)	is likely to aggravate his condition	(iii)
(c)	Was he to your knowledge under the influence of Intoxicants or drugs at the time of accident?	(c)
6. (a)	According to you how long has the Injured Person to be confined to bed/house as the dire and sole consequence of the injuries sustained?	(a)
(b)	During the period will the Injured Person be able to Attend to any portion of his normal duties? If, so From what date?	(b)
(c)	If not please state probable date of	(c)

Annex. 4 Contd.

(i) his being able to attend to any portion of his normal duties. (ii) his resumption of his normal duties fully	(i) (ii)
7. Any other remarks you wish to make	

I hereby certify that the injuries sustained by the person mentioned above are in accordance with the nature of the accident as described to be and that I treated him for the said injuries.

Place: Signature

Date: Name

Address

Qualifications

Registration No.

Note: The fee if any for this Report will be borne by the Injured Person.

ANNEXURE 5

(to be executed on a non-judicial stamp paper of Rs.15/-)

INDEMNITY BOND.

Indemnity Bond is being executed by Sponsoring Agency and Shri/Smt. .... son of/wife of ..... R/o ..... in favour of Oriental Insurance Co, Ltd., Divisional Office 10, 15-16 Scindia House, K.G. Marg, New Delhi –110 001

Whereas Sponsoring Agency had obtained policy of Insurance being Policy No. ..... and WHEREAS in a cyclone on or about .....Shri ..... is said to have died and is reported mission and WHEREAS the body has not yet been recovered and he is presumed to have died and a certificate to that effect has also been issued by the Sponsoring Agency and WHEREAS National federation of Fishermen's Cooperatives Ltd. has approached Oriental Insurance Co. Ltd. for settlement of claim on the grounds that Shri ....has died as a result of said cyclone and WHEREAS Oriental Insurance Co. Ltd. on the representation of the Director of Fisheries has accepted that Shri ..... has died and WHEREAS if by any chance later it is found that Shri ..... has not died and is still alive now therefore THE CONDITION OF THIS BOND IS THAT IF AT ANY TIME IT IS FOUND THAT SHRI ..... HAS NOT DIED AS A RESULT OF ACCIDENT AND CYCLONE, THE SPONSORING AGENCY AND SHRI/SMT. .....(Nominee) SHALL JOINTLY OR SEVERALLY RETURN TO THE ORIENTAL INSURANCE CO. LTD. THE SUM ASSURED PAID UNDER THIS CLAIM. In witness thereof parties have set hand on this ..... Day of ..... month ..... Year.

1. Sponsoring Agency WITNESSES

2. WIFE/SON

(Nominee) – Relationship