DIGIT EMPLOYEES COMPENSATION INSURANCE POLICY
CLAIM FORM
UIN: IRDAN158RP0020V01201920

1. **This form should be filled in by the Policyholder or an authorized Representative and must be signed and dated in all applicable sections.**
2. **The issue or acceptance of this form by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the terms and conditions of the insurance contract.**
3. **Claim form must be filled online or manually or using voice record at Call Centre.**
4. **Please answer all questions completely. In case of insufficient space, please attach an additional sheet.**
5. **Please attach all Original bills & receipts pertaining to your claim.**

INSURED DETAILS

1) Insured Name: _____
2) Address: _____
_____ PIN CODE_____
3) a) Mobile No_____3 b) Email Id _____
4) Policy No: _____
6) Business: _____

BANK NEFT DETAILS FOR CLAIM PAYMENT

I hereby declare that below bank details are correct and should be used to process all payment due in relation to my insurance policy.

1) Name on Bank Account: _____
2) Bank Name: _____ Account Number _____ Branch _____
3) Account Type: Saving/Current 4) IFSC Code: _____ 5) MICR Code_____
6) PAN Number: _____

DETAILS OF LOSS/ACCIDENT

Put a Tick (√) Mark where ever applicable.

DETAILS OF INSURED PERSON		
a.	Name of the Injured Person	
b.	State nature of work for which injured person was employed	
c.	Was the injured person engaged in the occupation when the accident occurred? If not, state exactly the nature of work he was doing.	
d.	Is the injured person in direct employment? Please provide details	
e.	Give details of his hospitalization / Medical treatment	
f.	State whether still in hospital, or when discharged	
g.	Has the injured person been medically examined If so, please share report? If not, was free medical examination offered?	
h.	State whether returned to work, and if so, when	
i.	Is the injured person able to do partial work?	
j.	What is the probable period of the disablement (approximate)?	
k.	Is the injured employee covered under any other policy (ESI / Personal Accident/any other) If Yes, Please provide details of the same?	
DETAILS OF ACCIDENT		
a.	Date, Time and Location of Accident	
b.	Did the accident occur actually within your work premises? If not, where did it occur?	
c.	On what date did you receive notice of accident and from whom? If in writing please attach to this form	
d.	Are you satisfied that the accident occurred in the course of and arising out of employment?	

e.	How exactly did the accident occur?	
f.	If accident due to machinery, state: (a) Whether it was fenced or guarded (b) Was it being cleaned whilst in motion	
g.	Was injured person under the influence of drink or drugs at the time of the accident?	
h.	Was he guilty of misconduct or disobedience to orders or rules? If so, please give full particulars	
i.	State through whose neglect, if any, it occurred	
j.	State the names of any person(s) who witnessed the accident	
k.	Please tick the Add-On Cover under which you need to claim	Medical Expenses Cover Occupational Disease Cover Coverage for Contractors Workers/ Employees

DECLARATION

- I/We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect and agree that if I have made any false or fraudulent statement or there be any suppression or concealment, no claim shall be payable resulting into forfeiture of premium and/or cancellation of policy.
- I/We have received a list of documents with this claim Form and have understood all the requirements to be fulfilled for administration of this claim.
- I/We agree to provide additional information to the Company, if required.
- I/We hereby do give consent that payment of claim amount be made to third person as per the bank details mentioned above

Name: **Signature of Insured/ Claimant:** **Date:**

STATEMENT OF INJURED PERSONS'S EARNING

STATEMENT OF WAGES: The object of this statement is to ascertain the injured persons average monthly earnings. Please therefore observe the following instructions very carefully. Failure to do so will entail unnecessary correspondence and cause undue delay in the settlement of the claim: -

1. If the injured person has been in the service during a continuous period (not broken by an absence of 14 or more consecutive days) of 12 months or more, then enter the wages paid to him in each month during 12 months immediately preceding the accident.

2. If he has been in the service during a continuous period of less than one month, then enter the wages paid to another workman employed on similar work during 12 months immediately preceding the accident.

3. In all other cases, the monthly wages shall be the average daily earnings (Amount of Wages/Actual number of days worked) multiplied by 30.

TABLE OF WAGES

Please fill in the table of wages below as applicable to 1,2 or 3 above.

Month and Year	Basic pay and Dearness Allowance	Overtime Bonus	Concession in value of food-stuffs and others	All others

Total earnings in the period (specify dates) _____ **Average monthly wages**_____

Were the above stated wages paid, or fallen due for payment, to the injured person? Yes / No

Was the injured person absent from work at any time, during the above stated period, for 14 or more consecutive days? Yes / No

If so, give the following particulars: -

Absent for_____days from _____to _____.

The above statement of earnings is accurate to the best of our knowledge and belief.

Place:

Date: Signature of Employer

Go Digit General Insurance Ltd, A Company incorporated under Indian Companies Act, 2013 and licensed by Insurance Regulatory and Development Authority of India [IRDAI] vide Reg No. 158, Corporate Identification Number U66010PN2016PLC167410, Reg. Address Atlantis, 95, 4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru 560095. Website: www.godigit.com

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CUSTOMER IDENTIFICATION PROCEDURE (AS PER KYC NORMS OF IRDAI)

1. **Please submit clear and legible copy of one document (valid and effective as on date of claim submission) each from Part A and Part B and your recent passport size photograph (not more than 6 months old) in case claim amount exceeds Rs 100,000.**
    a. **Photograph**
    b. **Part A (Identity proof, Anyone of below)**
        i. **PAN Card (If PAN Card is not available please submit any of the documents mentioned below)**
        ii. **Passport**
        iii. **Voter's Identity Card**
        iv. **Driving License**
        v. **Personal Identification and Certification of the employees for your identity**
        vi. **Aadhar (Letter issued by Unique Identification Authority of India containing details of name address and Aadhar Number)**
        vii. **Job Card issued by NREGA duly signed by an officer of the State Government**
    c. **Part B (Address proof, Anyone of below)**
        i. **Electricity Bill not older than 6 months from the date of Insurance Contract**
        ii. **Telephone Bill pertaining to any kind of telephone connection like mobile, landline, wireless etc, provided it is not older than 6 months from the date of claim submission**
        iii. **Ration Card**
        iv. **Valid lease agreement along with rent receipts which is not more than 3 months old as a residence proof**
        v. **Saving Bank Passbook with details of permanent/ present residence address (updated up to 1 month prior to claim submission document)**
        vi. **Statement of saving bank account with details of present/ present address (updated up to 1 month prior to claim submission document)**