UNITED BANK OF INDIA
LEAD BANK DIVISION
HEAD OFFICE
CONVENER : SLBC, WEST BENGAL

FI Awareness Series	Issue :1	Dated 14th November 2014

RuPay Card and its Benifits

What is RuPay Card ? What type of insurance coverage is available in RuPay Card?
RuPay Card is indigenous debit card issued by National Payments Corporation of India(NPCI). India is the 4th country after US, Japan and China to have its own debit card. Under PMJDY RuPay Card comes with in-built insurance coverage of Rs.1 lakh accidental death and permanent disability.HDFC Ergo is the insurance company for its purpose.
What is the eligibility criterion to avail Personal Accident Insurance cover on my RuPay Debit Card?
The claim under Accidental Death and / or Permanent Disablement shall be payable only if the RuPay Card holder has carried out at least one successful financial or non-financial transaction at a merchant establishment or at ATM or Micro ATM or ecommerce transaction, upto 45 days prior to the date of incident resulting into Accidental death/ Permanent Disability. Eligible transaction conducted in both On-us & Off-us environment will be eligible for the benefit of the Insurance Program.
Is there any age limit for availing Personal Accident Policy?
Personal Accident Insurance is open to everyone from the age of 18 years to 65 years. Age near birth shall be considered. It may be noted that age below 18 and beyond 65 year will not be eligible.
Is the insurance facility available on RuPay cards issued before 16.08.2014?
Accidental Insurance coverage of Rs.1 lakh is available on each RuPay Card issued before or after 16.08.2014.
Who will bear premium of the insurance on RuPay Card?
NPCI(National Payments Corporation of India) will bear the premium of insurance. Neither Bank nor customer needs to pay the premium.
If the incident occurs in a timeline of 0-45 days of issuance of the RuPay card, thereby not giving a window of the 45 days qualifying criteria for doing a transaction in order to be eligible for the insurance benefit, is the Cover still valid?
Yes as an exception in such cases the cover is still valid. However, it is strongly advisable to educate the customer for doing at least one transaction in each month to keep the policy active.
Is it mandatory to issue RuPay Card in accounts opened under PMJD Yojana? How to personalize the RuPay Card?
RuPay Card is to be issued to each account opened under PM Jan Dhan Yojana. To personalised the RuPay Card, name of the Acount holder is to be written on the card with Permanent Marker, before handling over to customer. Card is to be invariably activated in the CBS on same day after delivery.
In how many days should the beneficiary intimate about claim?
The claims can be intimated within 30 days of the date of accident
In how many days should the beneficiary subnit the claim?
The Claim Documents needs to be submitted within 60 days of the date of accident.
With whom the beneficiary should contact in case of a claim?
Please contact your Bank of which you have a card for intimating the claim.
How does the beneficiary make a claim?
Please fill the entire documents/ claim form etc as per checklist and submit the same to the Bank where you have an account.
What are the required documents required for lodging the claim?
Accidental Death Claim Forms : 1) Duly filled and signed claim form, 2)FIR copy,3) Post mortem report,4)Cause of Death- certificate,5) Death Certificate ,6) Viscera report (if done) ,7) Passport , Pan card, Aadhar card,address proof)KYC documents) 8) Copy of the RuPay Card/ Declaration from Bank on letter head with sign & stamp. 9) Switch Log/ Core Banking System screenshot from Bank for Transaction verification. 10) Declaration form Bank for nominee including NEFT details with sign & stamp (in case nominee is available/ legal heir certificate or any other document in discussion with claimant as a proof(in case nominee is not available with Bank)

Accidental Death

Claimant's Statement

Form 'E'

INSURED INFORMATION

Insured's Name________________________________ Date of Birth ___/____/____ Marital Status _____

Insured's Address ____

Name and address of Last Employer
____

Policy Number __________________________ Insured's Occupation (at time of death) __________________

Did the Insured have any other accident or life insurance? _________ If yes, please list all companies, policy numbers and insurance amounts:__ ____

CLAIM INFORMATION

Date of accident ______/_______/______ Time and place accident occurred____

Please describe in detail the circumstances of accident (attach separate sheet if needed):

____

____

Was the accident related to the Insured's occupation? ___________________ If so, how? ___________________________

Please describe the cause of the Insured's death:
____

Please list the names and addresses of all treating physicians and hospitals:____

____

Did police or other authorities investigate the accident? ____ If yes, please provide name, address and telephone number of all investigating officers and agencies: ____

Was an autopsy performed?______ If yes, please provide name and address of Medical Examiner____________________

____

Was a coroner's inquest held? _______If yes, what was the determination?_______________________________________

CLAIMANT INFORMATION

Claimant's Name____ Age_______ Relationship to Insured______________

Claimant's Address____ Phone No. (H)____________________________

____ Phone No. (W)____________________________

In what capacity are you making this claim? _____ Beneficiary ______ Executor* ______ Administrator* _____ Guardian* _____Trustee* _____Assignee*

*Please provide a certified copy of all documents supporting your authority (e.g., Succession Certificate, Notarised Affidavit, Notarised will, etc.)

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by HDFC ERGO General Insurance, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Place: ____

DATE ____/____/____ SIGNED (Claimant or authorized person)

Accidental Injury Claim
Claimant's Statement

Form 'A'

INSURED INFORMATION

Insured's Name_______________________________ **Date of Birth** ___/____/____ **Marital Status** ____

Insured's Address ____ **Phone No. (Off)**________________________

____ **Phone No. (Res)**______________

Name and address of employer ____

Policy Number __________________________ **Insured's Occupation** ____

Does the insured have any other insurance ? _________**If yes, please list all companies, type of insurance, policy numbers and insurance amounts:**____

____

CLAIM INFORMATION

Date of accident _____/_______/_______ **Time and place accident occurred**____

Please describe in detail the circumstances of accident (attach separate sheet if needed): ____

____

Was the accident related to the Insured's occupation? ___________________ **If so, how?** ____

Please describe the nature of Insured's injuries:____

Please list the names and addresses of all treating physicians and hospitals:____

____

____

Did police or other authorities investigate the accident? ____ **If yes, please provide name, address and telephone number of all investigating officers and agencies:** ____

CLAIMANT INFORMATION (If different than "Insured Information" above)

Claimant's Name____ **Age**_______ **Relationship to Insured**______________

Claimant's Address____ **Phone No. (Off)** ________________________

____ **Phone No. (Res)**________________________

In what capacity are you making this claim? ____

AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by HDFC ERGO General Insurance, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Claimant or authorized person) ____ **DATE** ____/____/____

Accidental Injury Claim
Claimant's Statement

Form 'A'

INSURED INFORMATION

Insured's Name________________________________ **Date of Birth** ___/____/____ **Marital Status** ____

Insured's Address ____ **Phone No. (Off)**________________________

____ **Phone No. (Res)**_____________

Name and address of employer ____

Policy Number ________________________ **Insured's Occupation** ____

Does the insured have any other insurance ? _________**If yes, please list all companies, type of insurance, policy numbers and insurance amounts:**____

____

CLAIM INFORMATION

Date of accident _____/_______/_______ **Time and place accident occurred**____

Please describe in detail the circumstances of accident (attach separate sheet if needed): ___________________________________

____

Was the accident related to the Insured's occupation? __________________ **If so, how?** ______________________________________

Please describe the nature of Insured's injuries:____

Please list the names and addresses of all treating physicians and hospitals:____

____

____

Did police or other authorities investigate the accident? ____ **If yes, please provide name, address and telephone number of all investigating officers and agencies:** ____

CLAIMANT INFORMATION (If different than "Insured Information" above)

Claimant's Name____ **Age**_______ **Relationship to Insured**______________

Claimant's Address____ **Phone No. (Off)** ________________________

____ **Phone No. (Res)**________________________

In what capacity are you making this claim? ____

AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by HDFC ERGO General Insurance, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Claimant or authorized person) ____ **DATE** ____/____/____

ANNEX - E

Declaration from the member bank (on bank's letter head)

(In case nominee details available with the member bank)

This is to hereby confirm that the Mr. / Ms. __________________ was issued a RuPay card vide no. ________________ issued by our bank, and as per the bank records the nominee details of the card holder is as mentioned below along with the NEFT details of the nominee.

Card Holder Name: ____________________________

RuPay Card Type: ______________________________

RuPay Card No:_________________________________

Nominee Name:________________________

Relationship with the nominee: _____________________

Bank Account No.: ___________________________

IFSC Code:__________________________

Bank Branch Name:________________________

Bank Address:

____

Authorized signatory

Bank seal

Accidental Injury
Hospital Cash Claim (Accident or Sickness)
Attending Physician's Statement

Form 'D'

INSURED INFORMATION

Insured's Name_________________________________ **Date of Birth** ____/____/___ **Marital Status** _____

Insured's Address____ **Phone No. (H)**_________________________

____ **Phone No. (W)**________________________

Name and address of employer ____

Policy Number_____________________________ **Insured's Occupation** ____

CLAIM INFORMATION

Date of accident: ____/ ____/____ **Date of first treatment:** _____/_____/_____

Please describe in detail the nature of the Insured's injuries,
____
____

Was the accident related to the Insured's occupation? ___________________ **If so, how?** ____

Was the Insured hospitalized? _______ **If yes, please list the names and addresses of all hospitals and all admission/discharge dates:**
____
____

Did the Insured have any injury or illness prior to the accident that contributed to the accident or to the Insured's present condition? ____
If yes, please describe: ____
____

Were any surgical procedures performed? ______ **If yes, please list all procedures, and dates performed:**
____
____

What are the Insured's current subjective symptoms? ____
____

What are the objective findings? (please include results of current x-rays, lab tests, etc.,)? ____
____

Dates of total disability: **Dates of partial disability:**

From: _____/_____/_____ **To:** ____/____/____ **From:** _____/_____/______ **To:** _____/_____/_____

Date Insured able to return to work: _____/_____/_____

Was the Insured seen by any other physician? ______ **If yes, please list the names and addresses of all other physicians:** ________________
____

ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician: ____ **Phone No.** _________________________

Address: ____

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Attending Physician) ____ **DATE** ____/____/____