PRADHAN MANTRI SURAKSHA BIMA YOJANA (PMSBY)
CLAIM-CUM-DISCHARGE FORM

(To be submitted preferably within 30 days of the occurrence of the accident of the insured member giving rise to the claim)

To be filled by the insured member in case of his accidental disability claim or by his nominee in case of death of insured member

(or in case the nominee is a minor, his/her appointee[1], and in case of no nomination or the nominee pre-deceasing insured member, the claimant[2] legal heirs of the insured)

Part 1. Details of the member enrolled under PMSBY

(1) Name:

(2) Address:

(3) Bank / post office account number:

(4) Name of Village /Town / City---------- Name of District----------

(5) Name of State----------PIN Code----------

(6) Day, date, and time of accident:

(7) Place of occurrence:

(8) Nature of accident[3]:

(9) Date of death:

(10) Cause of death / disability [4](please specify):

(11) Type of Disability (Total permanent or partial permanent):

(12) Document attached as proof of permanent disability[5] / death[6]:

(13) Aadhaar number[7] (Optional):

(14) Income-tax Permanent Account Number (PAN)[7] (Optional):

Part 2. Details of the nominee in case of death of insured member:

(or, in case the nominee is a minor, his/her appointee[1], and in case of no nomination or the nominee pre-deceasing insured member, the claimant[2] legal heirs of the insured)

1. Name of the nominee:
2. Age of nominee:
3. In case the nominee is a minor, name of the appointee[1]:
4. In case of no nomination or nominee pre-deceasing the insured member, name of the claimant[2]:
5. Proof of death[6] of nominee in case of nominee pre-deceasing the insured member:
6. Relationship of the nominee/claimant with the deceased:
7. Contact mobile number:
8. Contact email address:
9. Contact address:

10. Details of the nominee/appointee/claimant (as the case may be):

(1) Particulars of bank account into which the claim amount is to be remitted:

(a) Account number:

(b) Name of bank:

(c) Branch IFS Code:

(2) Aadhaar number[7](Optional):

(3) Income-tax PAN[7](Optional):

(4) KYC document[8] attached as proof of identity:

I hereby declare that details submitted above are true to the best of my knowledge, the documents attached in support of this claim are genuine, and I have not claimed the amount payable under PMSBY in respect of the member named above earlier or in respect of any other account of the member with any bank or post office.

Date:

(Signature of the insured member/
nominee/appointee[1]/claimant[2])

Attached documents:

(1) Proof of permanent disability due to accident5 or death due to accident6 of the insured member, as the case may be

(2) Aadhaar and PAN number of the insured member and claimant[7](Optional)

(3) KYC document[8] in respect of the nominee/appointee/claimant (as the case may be)

(4) First two pages of passbook, or bank / post office account statement showing account details, or cancelled cheque of the account of the nominee/appointee/claimant (as the case may be)

(5) Proof of death[6] of nominee in case of nominee pre-deceasing the insured member

(6) Proof of being legal heir, in case the claimant is other than the insured member/nominee/appointee

(7) Advance receipt for discharge of claim, duly filled in and signed

To be filled by the bank / Post office from enrolment data or data of bank/ post office

Part 3: Details in respect of the insured member

1. Bank / post office account number (as per bank's CBS/ post office records):

2. Bank / post office name:

3. Branch name:

4. Branch IFS Code:

5. Name of father/husband of the member:

6. Date of birth (as per the KYC document):

7. Name of the insurer:

8. Name of the nominee:

9. Date of debit of premium from the bank/ post office account:

10. Date of remitting the premium into insurer's account:

It is certified that the above information is true as per PMSBY enrolment data and bank / post office records.
Place:
Date:

(Signature and seal of the authorised official of the bank/post office)

PRADHAN MANTRI SURAKSHA BIMA YOJANA
Advance receipt for discharge of claim

In consideration of approval of my claim referred above, I hereby accept from _____ *(name of the insurer)* the sum of Rs. _____ (Rs. One lakh in case of permanent partial disability and Rs. two lakhs in case of permanent total disability or death) only in full and final settlement and discharge of my claim under the said policy covering insurance in respect of member Shri / Ms _____.

Signature of the witness
Name of witness:
Address:

Signature of the insured member/nominee/appointee/claimant
Date:

Countersignature of authorised official of the bank/ post office
Date:
Name:
Name of bank/ post office:
Branch:
Office stamp