



मानव संसाधन प्रबंधन विभाग, प्रधान कार्यालय  
प्लॉट सं. 4, सेक्टर 10, द्वारका, नई दिल्ली- 110075  
HUMAN RESOURCE MANAGEMENT DIVISION, HEAD OFFICE  
PLOT NO. 4, SECTOR-10, DWARKA, NEW DELHI-110075

TO ALL OFFICES

01-01-2025

HRMD CIRCULAR NO. 811/2025

**PERSONAL ACCIDENTAL INSURANCE COVER AND PREVENTIVE HEALTH CHECKUP & TELE CONSULTATION FOR PENSIONERS, THEIR SPOUSES & FAMILY PENSIONERS - RENEWAL OF POLICY FOR THE PERIOD FROM 01.01.2025 TO 31.12.2025 & MODALITIES FOR AVAILING BENEFITS**

The policy for Personal Accidental Insurance Cover and Preventive Health Checkup & Tele Consultation for Pensioners, their spouses and Family Pensioners up to 90 years of age at Bank's expense for the period 01.01.2024 to 31.12.2024 was obtained from M/s. Bajaj Allianz General Insurance Company. This was communicated vide HRMD circular no. 742 dated 01.01.2024 and HRMD circular no. 745 dated 12.01.2024.

We are pleased to inform that the aforementioned policy has been renewed for the period **01.01.2025 to 31.12.2025** with M/s. Bajaj Allianz General Insurance Company.

The salient features of the policy are as under:

**A. Personal Accidental Cover (PA):**

- **Sum Insured:** Rs.6 lakhs
- **Coverage:**
  - o **Death:** - 100% of Sum Insured; and
  - o **Permanent Total Disability:** - 125% of Sum Insured.

**B. Annual Preventive Health Check-up:** The insured can avail the following free preventive health checkups:

1. Liver function test
2. T3/T4/TSH
3. Serum Creatinine
4. Blood sugar – Fasting
5. Urine routine
6. HbA1C
7. Hemogram & ESR
8. Blood Urea
9. Lipid profile

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**C. Unlimited Teleconsultation:** Insured members can now consult a medical practitioner/physician/doctor listed on digital platform of M/s. Bajaj Allianz General Insurance Company for any illness or injury under the preventive Health Checkup Section.

**Modalities/Procedure for Availing Benefits:**

**A. Accessing Services:**

- Download the mobile application “**Bajaj Finserv Health**” from the Google Play Store.
- Sign up using the **mobile number registered in the HRMS record.**

**B. Updating Mobile Number:**

- Pensioners/Family Pensioner wishing to update their mobile number in the HRMS record and the Policy must **forward their request to the concerned Branch/Circle Office.**
- Pension-paying Branches/Offices can update mobile numbers in HRMS through the following navigation: **Manager Self Service >> Pension Management >> Pensioner Information.**
- **Circle Offices to forward the request** of retiree(s) for up-dation of mobile number along with **a confirmation of mobile number up-dation in HRMS record** also, to HO HRD for further necessary up-dation in the insurance policy.

The detailed procedure for availing benefits under the policy is provided in **Annexure - I.**

For assistance, contact details of officials from M/s. Bajaj Allianz General Insurance are listed in **Annexure – II.**

All concerned are advised to bring the contents of this circular to the notice of Pensioners/Family Pensioners and ensure smooth implementation of the policy benefits.

**(SURESH KUMAR RANA)**  
**CHIEF GENERAL MANAGER**

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**ANNEXURE – I**

**1. FOR UTILISATION OF PREVENTIVE HEALTH CHECKUP:**

- 1.1. After Sign up using Mobile Number as per registered Mobile number in HRMS record, go to **“My Active Plans”** then select **“Utilize”** option.
- 1.2. Then select **“Lab Benefit”** option.
- 1.3. Home collection facility is available at many locations. For locations where **home sample collection is not available**, the customer needs to **visit physically** and avail the tests benefit.
- 1.4. Select **“Home Collection”** or **“Lab Visit”** and then Click on **“Book Now”**.
- 1.5. After entering contact details and slot timings the appointment will be confirmed.

**2. FOR UTILISATION OF TELECONSULTATION COVER:**

- 2.1. After Sign up using Mobile Number as per registered Mobile number in HRMS record, go to **“My Active Plans”**.
- 2.2. Select doctor benefit option then select member (Self/Spouse) and choose option **“Consult Doctors Instantly”** or **“Book Video Consultation”**.
- 2.3. Choose specialization and confirm. The doctor will join the call for instant consultation.

**3. LODGEMENT OF CLAIM UNDER PERSONAL ACCIDENTAL COVER:  
DEATH AND PERMANENT DISABILITY:**

**A. Accidental Death:**

Accidental Death coverage entails the payment of the Sum Insured in the event of the insured person’s death within 12 Months from the date of coverage.

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**B. Permanent Total Disability:**

In the event of Permanent total disability caused by accident within 12 months from the date of coverage, lump sum payment of 125% of sum insured is provided. The permanent disability includes:

1. Loss of the sight of both eyes.
2. Physical separation of or the loss of ability to use both hands or both feet.
3. Physical separation of or the loss of ability to use one hand and one foot.
4. Loss of sight of one eye and the physical separation of or the loss of ability to use either one hand or one foot.

**Procedure to be followed for claim lodgment in case of Accidental Death/Permanent Disability:**

1. Submit the **Claim Form** (as per attachment) duly filled and signed by the Insured/Claimant.
2. Provide the beneficiary names against the policy and NEFT details of the beneficiary.
3. Completely filled NEFT details to be provided along with the Account number, IFSC code, Account Type, duly signed by the Nominee/Claimant with original preprinted cancelled cheque or 1st page of bank passbook or bank statement attested by the bank.
4. Documents to be submitted with Claim Form as under:

**IN CASE OF DEATH: -**

- Aadhar Card and PAN card of Nominee/Claimant.
- Attested copy of Death Certificate.
- Attested copy of FIR/Panchanama/Inquest.
- Attested copy of Post Mortem Report.
- Attested copy of Viscera/Chemical Analysis report, if any.

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- Hospitalization documents, if any.
- In case of Death, if nominee is not defined on the policy copy then notarized Legal Heir Certificate containing affidavit and indemnity bond on 200 INR, to be submitted duly signed by all legal heir.
- If nominee is minor, then Decree Certificate from court stating the guardian of the insured.

**IN CASE OF PERMANENT TOTAL DISABILITY: -**

- Aadhar Card and PAN card of Nominee/Claimant.
- Duly Filled Medical Certificate attached in the personal accident claim form.
- X-ray Films/Investigation reports supporting the diagnosis.
- PTD certificate from the govt. authority certifying the disability of the insured.
- Photograph of the patient before and after the accident to support the disability.

The Claim Form along with the requisite documents is to be sent to either of the following addresses:

- Bajaj Allianz General Insurance Company Limited: Block No 4, DLF Tower, 15, Shivaji Marg, New Delhi - 110015.
- Bajaj Allianz General Insurance Company Limited: Bajaj Allianz House, Airport Road, Opp. Gunjan Theatre, Yerwada, Pune - 411006.

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**ANNEXURE – II**

**Contact details of M/s. Bajaj Allianz General Insurance Company Officials**

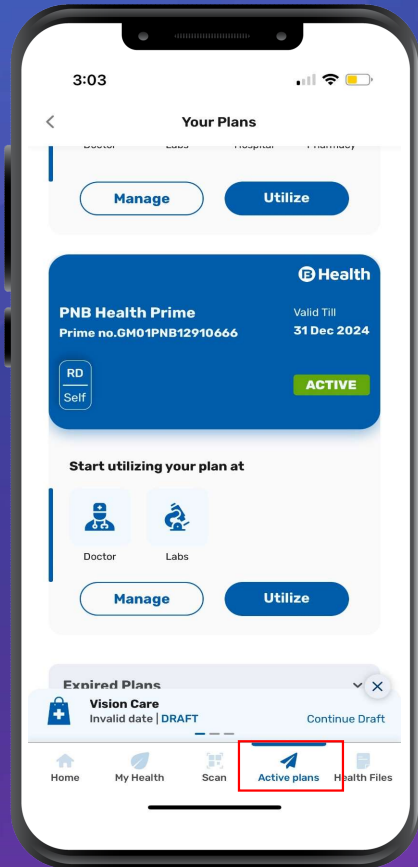
Location	Service RM	Mobile	1st Escalation Level with Mobile NO	2nd Escalation Level with Mobile NO
Bhubaneshwar	Sovan Mahato	7061953317	Abhishek Rout (9108767433)	Sarwar Hussain (7033592115)
Kolkata 2	Anupam Guchhait	8509385985		
Kolkata 2				
Siliguri	Priti Saha	8670433025		
Guwahati	Munmi Deka	7576841636		
Patna	Manish Singh	8804391058		
Indore 2	Kunal Parmar	9827780008	Manish K Singh (8109954363)	
Bhopal	Saurabh Sharma	9753185653		
Ranchi	Rahul Singh	8709193129		
Raipur	Abhishek Singh	9981121561		
Allahabad	Alok Anand	9430919701	Amit Singh (9315497796)	Dheeraj Kapoor (9711636969)
Lucknow	Amit Singh	9315497796		
Kanpur	Abhinav Mishra	8588893684		
Meerut	Shubham Goyal	8630060842	Rakesh K Pandey (9999115167)	
Delhi 2	Shivank Bhargav	9549197652		
Delhi 2	Madhav Singh	7703997267	Sidhant Jhinjha (9571453900)	
Ludhiana	Gurpreet Singh	9478949481		
Jaipur	Priyanka Jakhar	7014763198		
Amritsar	Parduman Verma	7837748868	Pavan Reddy (9972692324)	Sasi Reddy (8886969117)
Bangalore	Pavan Reddy	9972692324		
Chennai	Jayanth P	9392058752		
Cochin	Abhinav Nambi K	9656041460		
Madurai	Tambi Durai	9791555771		
Coimbatore	Gokila Gayu	8754786608		

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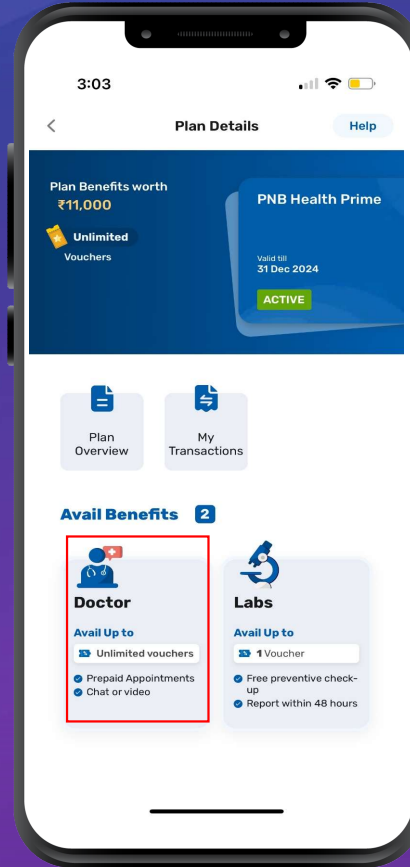
Location	Service RM	Mobile	1st Escalation Level with Mobile NO	2nd Escalation Level with Mobile NO
Hyderabad	Narkuri Murali	9912438838	Siddhartha Nayak (9533963727)	
Vizag	Palla Ajith	8639880470		
Tirupati	K Balaji	9951676664		
Baroda	Ankit Srivastava	8115155432	Anand Yadav (9039982930)	Sagar Saxena (7045043477)
Ahmedabad	Devendra H Koshti	7777990780		
Surat	Surya Pal	9575599354		
Mumbai	Rajat Phulkar	7077177727	Nitin Singhal (9997303456)	
Mumbai	Prachi Dwivedi	8299465084		
Mumbai	Richa Saxena	9871413978		
Mumbai	Narayan Sawant	9833995108		
Nagpur	Atul Jain	7720035630	Anima Kumud (9561164195)	
Nashik	Baba Saheb Wagh	9960810608		
KOLHAPUR	Vaibhav Chougule	9970062026		
Pune 2	Asif Shaikh	9834214464		
Aurangabad	Santosh Zampa	7020656413		

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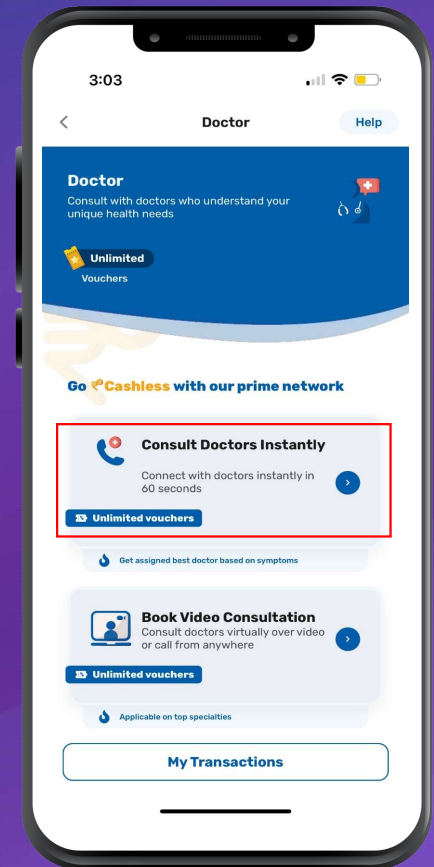
# How to utilize Insta-consultations?



Click on Plan card from "My Active Plans"



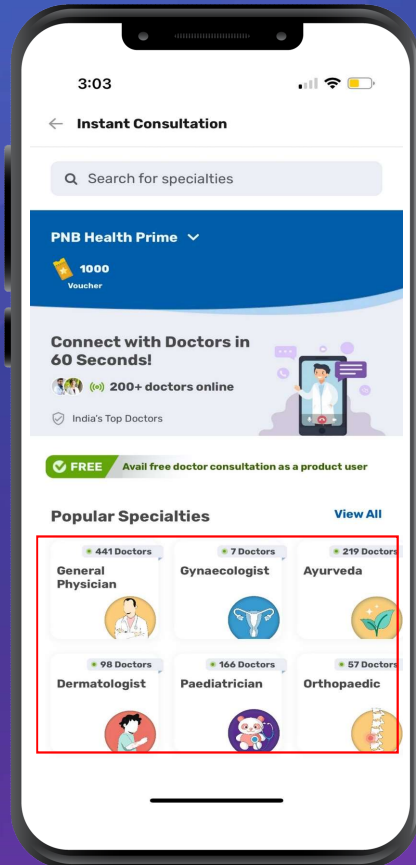
Click on "Doctor"



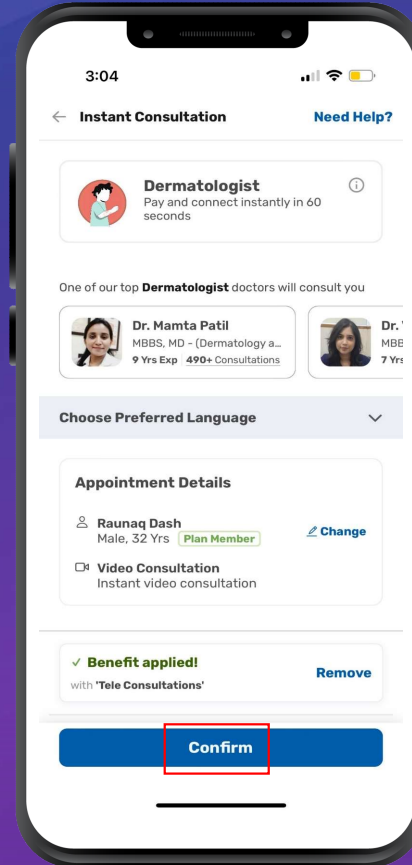
Click on "Consult Doctors Instantly"



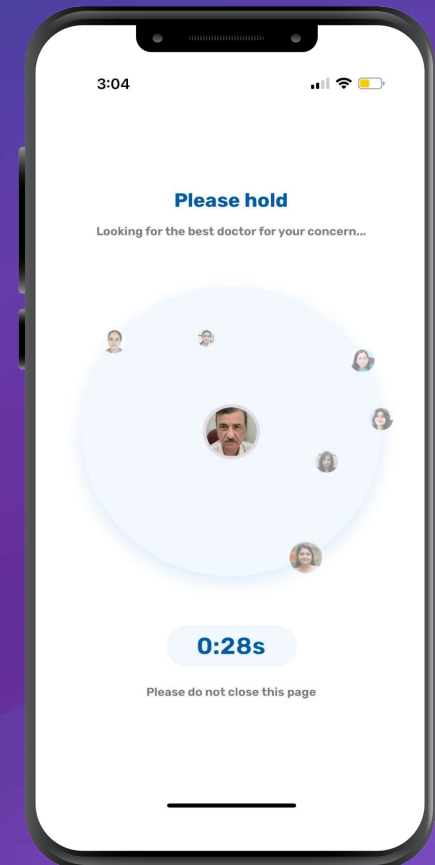
# How to utilize Insta-consultations?



Select your specialization



Review details and click on "Confirm"

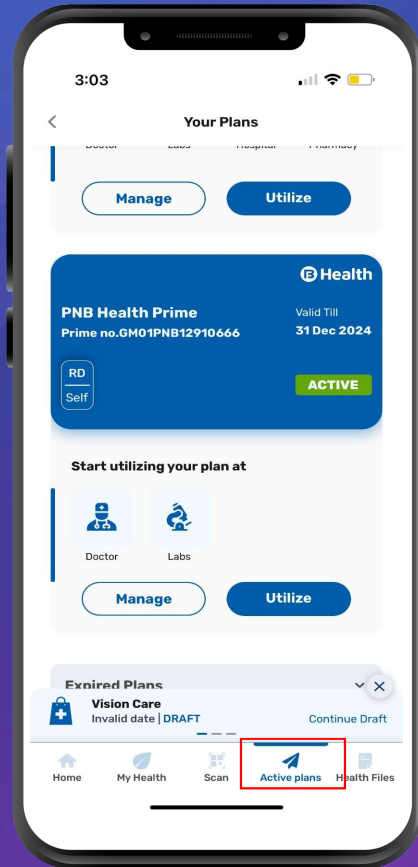


Your Insta-consultation will begin in 30 secs!

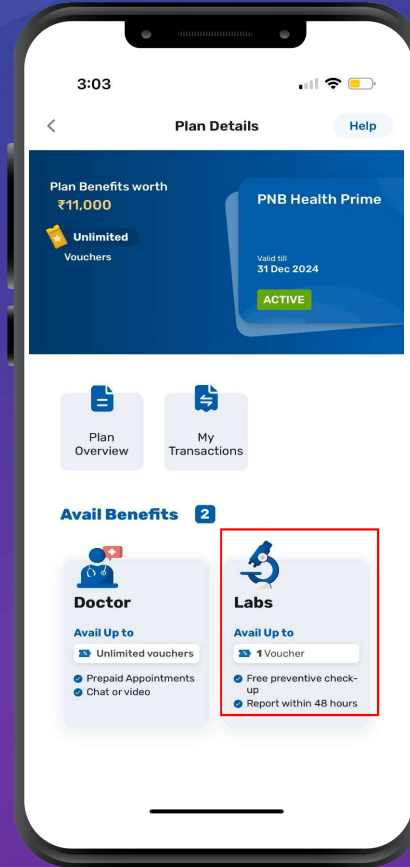
# Our Lab Partners



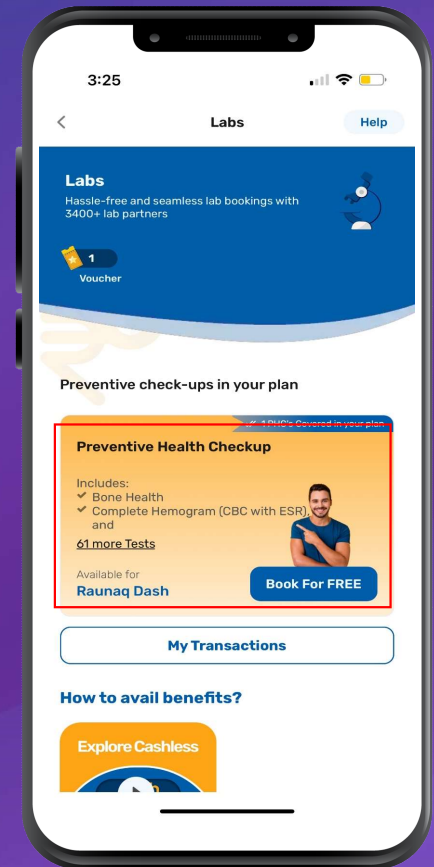
# How to utilize PHC?



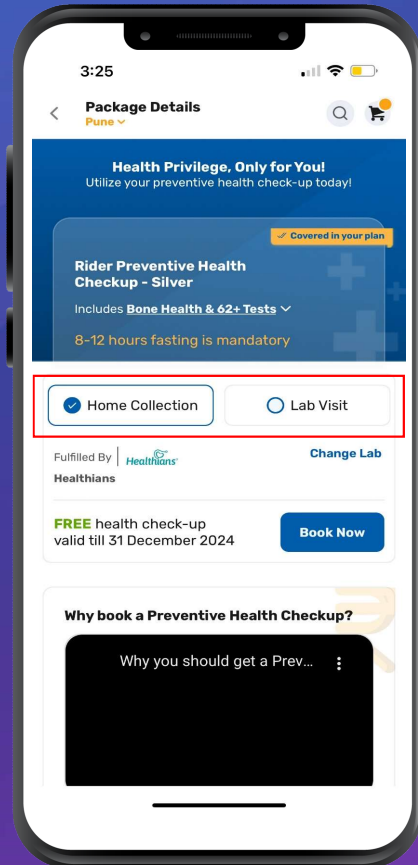
Click on plan card from "My active plans"



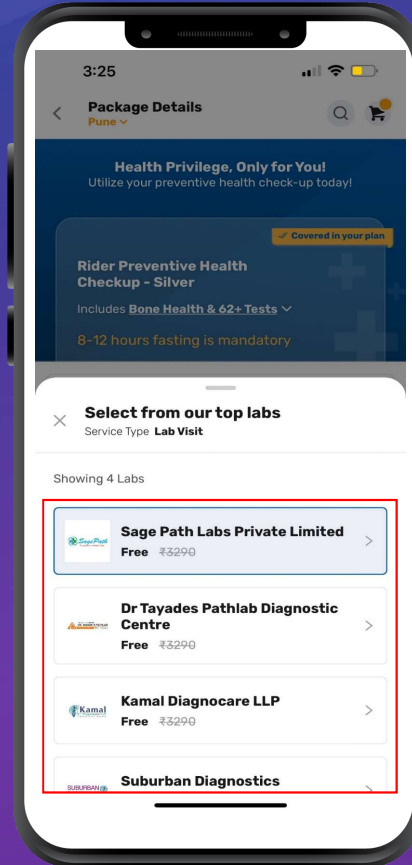
Click on "Labs"



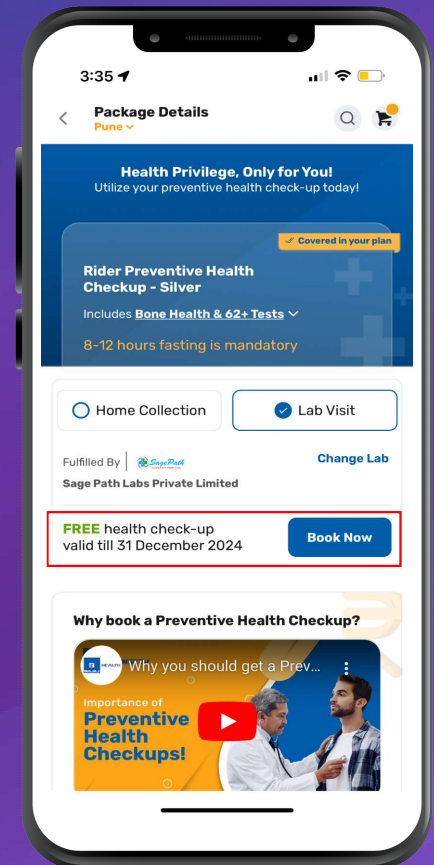
Click on your PHC card



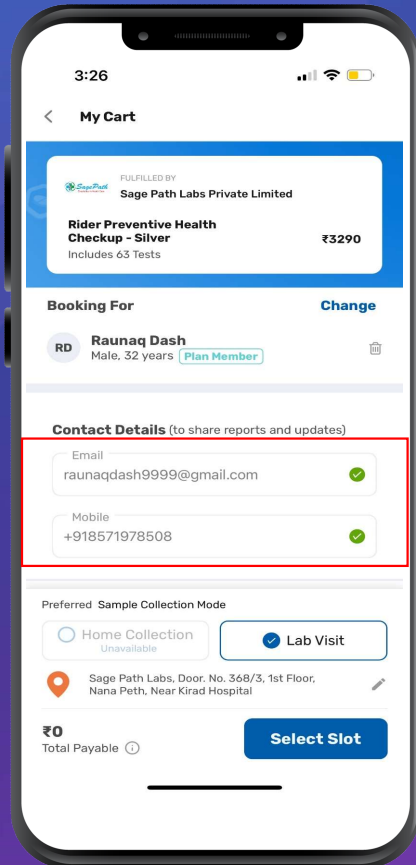
Select "home" or "lab"



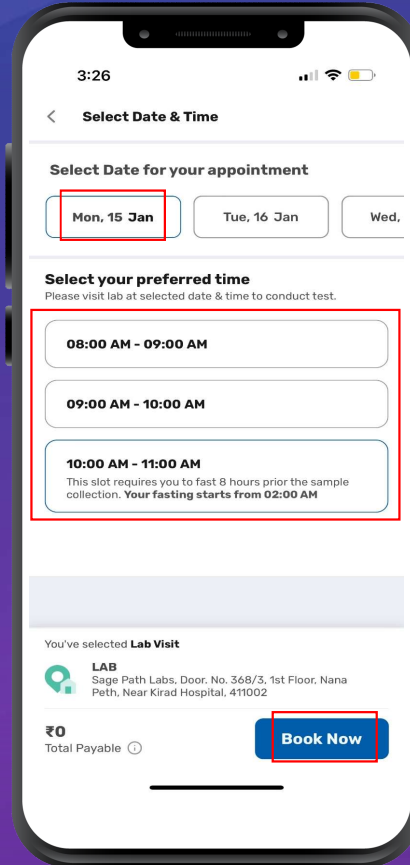
Select provider



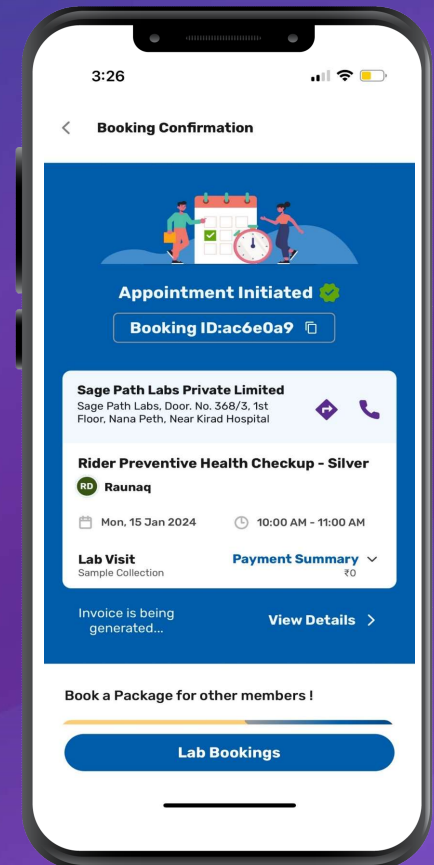
Click on "Book Now"



Enter Contact Details



Select Slot Timings



Click on "Book Now" and appointment is confirmed

(To be filled in block Letters)

**CLAIM FORM FOR GROUP PERSONAL ACCIDENT POLICIES**

Policy No.	
Claim No.	
Corporate Name	
Address of the Unit/ Location.	

Policy issued Name or Unnamed basis  Named  Unnamed

Please confirm if insured with any other Insurance or Offices granting compensation for accident?

If Yes Kindly provide name of insurance company and policy number and Sum Insured \_\_\_\_\_

**Insured / Proposer Details**

1	Name of the Insured/ Proposer									
2	Profession or Occupation									
3	Employee Number	Employee Date of Joining <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y			
4	Name of the insured person died/injured in the accident									
5	Relationship With Employee/ Proposer									

**6 Address of the Insured**

House No.		Area	
City		State	
Pin code		Contact Number	
E-Mail ID:			
Aadhar Card Number /UID:		PAN Card Number	
CKYC on Nominee / Insured can be added			

**7 Claims under Which Benefits (Tick against the benefit)**

Death  Permanent Partial Disability  Permanent Total Disability  Temporary Total Disability  Accidental Hospitalization  Hospital Cash  
 Medical Expenses  Children Education Bonus  Transportation / Ambulance  Burial Expenses / Mortail Remains  
Others (Please Specify) \_\_\_\_\_

8	Date and Time of the Accident	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y			
	Where did it happened / Location									
	Where did it happened / Location									
	Final Ailment									

9	Whether Accident Reported to Police?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes Please confirm FIR / MLC (Details) MLC report and Police FIR attached	<input type="checkbox"/> Yes <input type="checkbox"/> No

10	Is there any Accidental Hospitalization? If Yes Please confirm Date of admission and Date of Discharged	Date of Admission <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y	Date of Discharge <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y												
D	D	M	M	Y	Y	Y	Y												

11	Name of the Hospital	
	Address of the Hospital	

12	Name of the Treating Doctor									
	Address of the Treating Doctor									
	Contact details of the Treating Doctor									
13	In case death of insured, please mention Date of Death	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y			
14	In case of Death , if beneficiary is Employee , Please provide the Nominee Details:									
	a) Address of Nominee									
	b) Contact Details of nominee									
	c) Aadhar Card / UID Details of Nominee									
	d) PAN Card Details of Nominee									
15	Permanent Total Disability/Permanent Partial Disability/Temporary Total Disability Medical Certificate from Treating Doctor Mandatory as same attached in the Claim Form									

In Support of the claim, I enclosed the below tick documents along with the claim form.

Common Documents for Group Personal Accident.	Benefits.
<input type="checkbox"/> Claim form duly filled and signed by the insured / Claimant. <input type="checkbox"/> Beneficiary Name against the Policy and NEFT Details of Beneficiary: Corporate / Employee <input type="checkbox"/> Completely filled NEFT details stating Branch, Branch IFSC Code, Account type, Complete Account Number duly signed by Nominee / Claimant with original pre printed cancel cheque if pre-printed cheque is not available Kindly provide 1st Page of Bank Pass Book/ Bank statement Attested by the Bank which clearly indicates Beneficiary Name & Complete Account no as well IFSC code.(All Fields in the form are mandatory to process). <input type="checkbox"/> Aadhar Card & Pancard details of Nominee / Claimant. <input type="checkbox"/> In case of Unnamed Policy we will require Salary Slip at the time of issuance of the policy for Salary Commensuration. <input type="checkbox"/> In case of Unnamed Policy Kindly provide the attendance record/Roll from the Employer duly signed and sealed by the employer (For Confirmation of Total Number Of Employees On Roll at The Time Of Accident).  <b>Accidental Hospitalization:</b> <input type="checkbox"/> Original Discharge Summary. <input type="checkbox"/> All the previous Consultation Papers <input type="checkbox"/> Investigation Reports supporting the diagnosis. <input type="checkbox"/> Operation Theatre Notes <input type="checkbox"/> Original Final Bill with detailed bill break up and Paid Receipts <input type="checkbox"/> Original Pharmacy and Investigation Bills	<b>Death:</b> <input type="checkbox"/> Attested copy of Death certificate <input type="checkbox"/> Attested copy of FIR / Panchanama / Inquest <input type="checkbox"/> Attested copy of Post Mortem Report <input type="checkbox"/> Attested copy of Viscera /Chemical analysis Report if any <input type="checkbox"/> Hospitalization documents, if any <input type="checkbox"/> In case of Death if Nominee is not defined on the policy copy then we will require the below documents <input type="checkbox"/> Legal heir certificate containing affidavit and indemnity bond on 200 INR (As per attached format).The same should be duly signed by all legal heirs, notarized. <input type="checkbox"/> If Nominee is minor then we will require Decree Certificate from Court stating the guardian of the insured  <b>Permanent Partial Disability and Permanent Total Disability:</b> <input type="checkbox"/> Duly filled Medical Certificate attached in the Group Personal Accident Claim Form. <input type="checkbox"/> X-ray films /Investigation reports supporting the diagnosis. <input type="checkbox"/> Permanent Total Disability and Permanent Partial Disability Certificate from the Government authority certifying the disability of the insured. <input type="checkbox"/> Photograph of the patient before and after the accident to support the disability.  <b>Temporary Total Disability :</b> <input type="checkbox"/> Duly filled Medical Certificate attached in the Group Personal Accident Claim Form <input type="checkbox"/> Leave certificate from employer stating the exact leave period, duly signed and sealed by the employer. <input type="checkbox"/> All the consultation papers with details of treatment during TTD period. <input type="checkbox"/> Final medical fitness certificate from treating doctor stating the type of disability, disability period and declaration that patient is fit to resume his duty on given date. <input type="checkbox"/> X-ray films /Investigation reports supporting the diagnosis.  <b>Add On Cover:</b> <b>Children Education Bonus:</b> <input type="checkbox"/> In Case of Death and PTD, Kindly provide bonafide certificate from the school authorities stating that child of the insured is studying over there. (Mentioning - Name, S/D/o, Date of Birth and Class) School Identity Card.  <b>Burial Expenses &amp; Transportation Expenses:</b> <input type="checkbox"/> Original Paid Receipts  <b>Hospital Cash Expenses:</b> <input type="checkbox"/> Copy of Final Bill and Discharge Summary. <input type="checkbox"/> Investigation reports toward diagnosis.

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

(Submission of Cancelled Blank Cheque Leaf with Payee Name Printed OR Copy of the First page of the Bank Passbook is Mandatory)

Name of the Account Holder  
(As per Bank Account) \_\_\_\_\_  
Bank Account No (As per  
appearing in the cheque book): \_\_\_\_\_  
Bank Name: \_\_\_\_\_  
Bank Branch Address: \_\_\_\_\_  
IFSC Code: \_\_\_\_\_ MICR Code: 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Account Type:  D Saving  D Current  D Cash Credit

I/We authorize Insurance Company/TPA to contact me/us through SMS/Email/WhatsApp for any update on this claim.

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize Bajaj Allianz General Insurance Company Limited, to seek necessary medical information/ documents from any hospital/ Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills/ receipts for the purpose of this claim.

1. For retail policies/individual customers:

Consent/Declaration to be added in proposal and claim for CKYC no.:

I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or National Securities Depository Limited Portal for the purpose of undertaking KYC verification.

2. For Juridical person/non-individual customer:

Consent/Declaration to be added in proposal and claim for CKYC no.:

I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or Goods and Service Tax Portal or Ministry Of Corporate Affairs Portal or National Securities Depository Limited portal for the purpose of undertaking KYC.

3. For Group Policies:

Consent/Declaration to be added in claim form CKYC no.:

I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry for the purpose of undertaking KYC

4. For Juridical person/non-individual customer and Group Policies:

Consent/Declaration to be added in claim form CKYC no.:

I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC

Witness:

Witness Name: \_\_\_\_\_

Date:

--	--	--	--	--	--	--	--

\_\_\_\_\_  
Signature of the Witness

\_\_\_\_\_  
Signature of the HR officer of Unit/ Location

Name of Claimant/ Proposer: \_\_\_\_\_

\_\_\_\_\_  
Name of Claimant/ Proposer:



**MEDICAL CERTIFICATE**

(Claim must be supported by the Medical Evidence furnished by the Insured at his/her expense)

1 (a)	Name of Claimant	
(b)	Age / Gender	
2(a)	Type of disability	<input type="checkbox"/> Permanent Total Disability <input type="checkbox"/> Permanent Partial Disability <input type="checkbox"/> Temporary Total Disability
	Date and Circumstances of Injury stating diagnosis and details of Injury	
	Date on which you first attended claimant for this injury	
	If Injury give cause	<input type="checkbox"/> Self-inflicted <input type="checkbox"/> Assault <input type="checkbox"/> Road Traffic Accident <input type="checkbox"/> Substance Abuse /Alcohol Influence <input type="checkbox"/> Others (Please Specify) _____
	If Medico legal Done :	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Reported to Police:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Extent of Disablement for Permanent Total Disability and Permanent Partial Disability as per Extraordinary Gazette Notification issued by Ministry of Social Justice & Empowerment, GOI, Part II, Sec. 1, June 13, 2001	Date Of Injury :- Disability% :-
	Period of Temporary Total disablement (From Date of Injury to Fit to resume his Duty Date.	Date of Injury: Fit to resume his Duty Date on: No of Days
	Is claimant suffering from any disease or illness apart from his injury and is there any illness by circumstances which may tend to retard recovery? If so, give particulars	
	Present State of Incapacity	<input type="checkbox"/> Fit <input type="checkbox"/> Disable

Having personally examined the above named Insured, I certify that the above statements are correct and that the injured person is necessarily disabled by the accident referred to.

Name of the Doctor \_\_\_\_\_

Qualification & Registration Number: \_\_\_\_\_

Address: \_\_\_\_\_



Seal and Signature