



शैक्षणिक वर्ष २०२५-२०२६ करिता प्रवेशित विद्यार्थ्यांसाठी 'स्वामी विवेकानंद युवा
सुरक्षा योजना' ही विद्यार्थी वैयक्तिक अपघात विमा योजना सुरु

यशवंतराव चव्हाण महाराष्ट्र मुक्त विद्यापीठाच्या वतीने शैक्षणिक वर्ष २०२५-२०२६ पदविका (Diploma), पदवी (Graduation), पदव्युत्तर पदवी (Post Graduation) या पैकी कुठल्याही शिक्षणक्रमास प्रवेशित विद्यार्थ्यां करिता 'स्वामी विवेकानंद युवा सुरक्षा योजना' ही विद्यार्थी वैयक्तिक अपघात विमा योजना सुरु केलेली आहे. सदर विमा " उच्च व तंत्र शिक्षण विभाग, शासन निर्णय क्र. संकीर्ण २०२१ / प्र. क्र.१४ / वि शि ५ दिनांक २८ नोव्हेंबर २०२३ नुसार विद्यापीठाने चोला मंडलाम एम एस जनरल इन्शुरन्स कंपनी ह्यांच्याकडून विद्यार्थी वैयक्तिक अपघात विमा उतरविण्यात आला आहे. यामध्ये शैक्षणिक वर्ष २०२५-२०२६ प्रवेशित विद्यार्थ्यांचा अपघाताने दुर्दैवी मृत्यू झाल्यास अथवा पूर्णतः अपंगत्व आल्यास खालील प्रमाणे लाभ मिळू शकतो.

अ. क्र	अपघात तपशिल	विमा राशी
१.	Accidental Death	रु ३,००,००० /-
२.	Permanet Total Disablemet	रु ३,००,००० /-
	Disability	% Of SI
२.१	Loss Of Sight Of Both The Eyes	100 %
२.२	Loss Of Two Entire Hands Or Two Entire Feet	100 %
२.३	Loss Of One Entire Hands Or One Entire Feet	100 %
२.४	Loss Of Sight Of One Eyes And Such Loss Of One Entire Foot Or Hand	100 %
२.५	Complete Loss Of Hearing Of Both Ears And Complete Loss Of Speech	100 %
२.६	Complete Loss Of Hearing Of Both Ears Or Complete Loss Of Speech And Loss Of One Limb Or Loss Of Sight Of One Eye	100 %
३.	Modification Of Residential Accommodation And Vechile	रु १,००,०००/-

सदरील विमा योजनेमध्ये शैक्षणिक वर्ष २०२५-२०२६ करिता प्रवेशित विद्यार्थ्यांचा एकूण ३,००,०००/- रुपयेचा विमा उतरविण्यात आलेला आहे. अपघाताने मृत्यू झाल्यास रु ३,००,०००/-, अपघाताने वरील २.१ ते २.६ नुसार घटना घडल्यास ३,००,०००/- रुपये व Modification Of Residential Accommodation And Vechile करिता १,००,०००/- रुपये या प्रमाणे विमा परतावा मिळतो.

लाभार्थी विद्यार्थ्यांना या योजनेचा लाभ मिळणे साठी वा अधिक माहिती घेण्यासाठी दूरध्वनी क्र. ०२५३- २२३०१२७ संपर्क साधावा तसेच अर्ज आवश्यक कागदपत्रासह विद्यार्थी कल्याण व बहिःशाल केंद्र, य.च.म.म.वि, नाशिक .४२२२२२. या पत्त्यावर पाठवावे.


ईमेल : paclaims@cholams.murugappa.com , cc to- dir_dsw@ycmou.digitaluniversity.ac मेल करावा.




चोला मंडलाम एम एस जनरल इन्शुरन्स कंपनी संपर्क क्रमांक

LEVEL 1	PRASANT DEORE	SALES MANAGER	8698291423 / deorep@cholamsispl.com
LEVEL 2	SANJAY PARONDE	AREA MANAGER	9090494228/ parondesanjays@cholams.murugappa.com
LEVEL 3	AMOL WARE	REGIONAL MANAGER	9373697458/ amolwa@cholams.murugappa.com

सोबत : विद्यार्थी वैयक्तिक अपघात विमा Chola Ms General Insurance Personal Accident Clams
Processing - SOP


प्रमुख, विद्यार्थी कल्याण व बहिःशाल केंद्र


शैक्षणिक संयोजक,
विद्यार्थी कल्याण व बहिःशाल केंद्र


मा. कुलसचिव

PERSONAL ACCIDENT CLAIMS PROCESSING- SOP

Benefits covered under policy-

2.1. Accidental Death

The Sum Insured as stated in the Schedule will be paid if the death of the Insured Person occurs within a period of twelve months from the date of Injury, and such Injury be the sole and direct cause of death of the Insured Person.

2.2. Permanent Total Disablement

In the event of Injury, causing the Insured Person Permanently Totally Disabled such disability has continued for a period of 12 consecutive months. We will pay the Insured Person the percentage of the Sum Insured shown in the table below:

Disability	% of SI
Loss of sight of both the eyes	100%
Loss of two entire hands or two entire feet	100%
Loss of one entire hand and one entire foot	100%
Loss of sight of one eye and such loss of one entire foot or hand	100%
Complete loss of hearing of both ears and complete loss of speech	100%
Complete loss of hearing of both ears or complete loss of speech and loss of one limb or loss of sight of one eye	100%

2.8. Modification of Residential Accommodation and Vehicle

In the event of Injury, We will reimburse upto the Sum Insured for covered expenses reasonably incurred to modify the Insured Person's residential accommodation or own vehicle on account of the Insured having suffered Permanent Total Disability subject to the condition that these alterations are necessary as per the advice of treating/ attending Medical Practitioner. Benefit under this section is payable subject to the claim under Permanent Total Disability under the policy becoming admissible

Intimation:

The intimation of a claim needs to be provided to Chola MS through the following modes of intimation:

➤ paclaims@cholams.murugappa.com

Forwarding the Claim Documents:

All the document pertaining to PA claims will be sent to paclaims@cholams.murugappa.com.

Modes of Claim Processing:

The modes of processing for claims arising out of GPA Benefit policies as follows:

I. Claim Processing: Various stages involved in processing an Accidental Death & PPD/PTD/TTD claim is as given below:

Address to dispatch the claim documents: **CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED**

Head Office: New No. 819 Old No. 134, Shree Welfare Building, 2nd Floor, Thambu Chetty Street, Chennai - 600001. T: +91 (0) 44 4044 5400

Chola MS customer support operates 24*7 basis and the contact details are as followed for any queries / grievance. Toll Free Phone No. **1800-208-5544** | E Mail: customercare@cholams.murugappa.com

Claim documents are shared as Soft copies to designated Mail ID as per mutually agreed process. On receipt of the same all the documents are checked in terms of whether policy is booked, duly filled in claim form & along with other mentioned documents are forwarded to Claims Inward team to inward the same in the system. Our Inward Team Notify the claim, Claim no generated and Registered in the system (Cordys).

Notification: - At this stage the unique Claim no is generated

Claim Inward: Uploading the received documents under the specified claim

Registration: - Verified the submitted documents and claim is registered

- I) **Claim Adjudication** - Claim is adjudicated to verify the admissibility of the claim and accordingly based on the merits under policy T & C the claim will be approved / Query raised/ recommended for investigation / repudiated .
- II) **Approval** – Claim Approved will be taken up by the NEFT team for NEFT document verification and penny cart test accordingly, if all documents are in order, the claim is recommended for payment to our Finance team.
- III) **Investigation process** - Claims recommended for investigation by the adjudicating team will be taken up separately after the required investigation is done and the decision on the same will be taken up based on the investigation remarks and investigation teams recommendations.
- IV) **Query Process** - In case of any deficiency in the submitted documents, appropriate query to be raised. Query requirement details is shared with the partner periodically and if the response is not received, follow up is done through reminders. Queries pending more than 45 days, the claim will be closed.
- V) **Closure of claim:** In case of non-receipt of the deficiency sought from the insured/claimant, the claim will be closed after sending the mandatory four reminders (15 days interval). The MIS conveying closure of the claim would be sent to the Partner. Claim will be closed on 45th day if there is no response from the member.
- VI) **Repudiation of claim** – If claim should be repudiated and letter conveying the grounds of repudiation explaining the relevant policy terms and conditions should be sent to the Insured/Nominee.

The closure or repudiation of a claim would also ensure that reserves in the claim are nullified and software is suitably updated.

Claim process TAT – various stages:

- Claim intimation and furnishing of documents within 30 days of occurrence of accident.
- Claim process: within 30 days of submission of complete set of documents for Death claims

Escalation Matrix:

LEVEL	PERSON NAME	DESIGNATION	EMAIL ID
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LEVEL 1	KANNAN N	MANAGER CLAIMS	kannann@cholamsispl.com
LEVEL 2	PRADEEP S	DGM CLAIMS	pradeeps@cholams.murugappa.com
LEVEL 3	Dr. MADHUSUDAN RAO KONDETI	AVP & Head – HAT CLAIMS	madhusudanrao@cholams.murugappa.com

Contact person at NASHIK.

1. LEVEL 1 – Mr.Prashant Deore (Sales Manager) - 8698291423
2. LEVEL 2- Mr.Sanjay Paronde (Area Manager) - 9090494228
3. LEVEL 3- Mr.Amol Ware (Regional Manager) - 9373897658

PERSONAL ACCIDENT CLAIM FORM

CRM Intimation No	Claim No		
Policy No	From		To
Sum Insured			
Policy Purchased From:	<input type="checkbox"/> Online	<input type="checkbox"/> Agent	<input type="checkbox"/> Broker <input type="checkbox"/> Bancassurance
Having any policy from another company:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Company Name			
Policy No	From		To
Sum Insured			

WHICH BENEFIT TO AVAIL : PLEASE TICK

Accidental Death <input type="checkbox"/>	Permanent Total Disability <input type="checkbox"/>
Permanent Partial Disability <input type="checkbox"/>	Temporary Total Disability <input type="checkbox"/>
Education Benefit <input type="checkbox"/>	Accidental Weekly Benefit <input type="checkbox"/>
Any other benefit	

COMMUNICATION ADDRESS FOR CLAIMS REQUIREMENT

Claimant Name			
Age	Gender:	Male <input type="checkbox"/>	Female <input type="checkbox"/> Transgender <input type="checkbox"/>
Marital Status	Single <input type="checkbox"/> Married <input type="checkbox"/>		
Relation with the Injured/Deceased			
Communication address		<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	
Door No	Street Name		
Taluk	District/City	State	
Pincode	Contact No:	Email Id:	

INFORMATION ABOUT INJURED/DECEASED PERSON

Insured Name			
Age	Gender:	Male <input type="checkbox"/>	Female <input type="checkbox"/> Transgender <input type="checkbox"/>
Marital Status	Single <input type="checkbox"/> Married <input type="checkbox"/>		

Occupation:	<input type="checkbox"/> Private <input type="checkbox"/> Service	<input type="checkbox"/> Self Employee	<input type="checkbox"/> Salaried
Nature of work			
Employee Id No	Company Name		
Annual Income	Designation:		

INFORMATION ABOUT ACCIDENT

Natural <input type="checkbox"/>	Unnatural <input type="checkbox"/>	Homicide <input type="checkbox"/>	Suicide <input type="checkbox"/>
Date of Accident	Time		
Accident Location with Address			
Detailed Description Of The Accident:			
Any Eye Witness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Relation	<input type="checkbox"/> Unknown
Witness name with address:			
Contact No			

HOSPITAL DETAILS

Any treatment taken after an accident		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hospital Name with Address			
If multiple hospital, please mention the details			
MLC No:	Date of Admission	Date of Discharge	
Date of Death	Place of Death with Address		
Cause of Death			

POLICE INTIMATION DETAILS

Whether Accident Intimated To Police		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Whether Police Verified the Accident Spot		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Police Station Name with Address			
MLC No:	FIR no.	Date of FIR	Time
Complaint Name with Relation Details			
FIR against For whom:		IPC Section	

Address to dispatch the claim documents: CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED

HAT Claim Office: New No. 319, Old No. 154, Shaw Wallace Building, 2nd Floor, Thambu Chetty Street, Chennai - 600001. T: +91 (0) 44 4044 5400

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POST MORTEM DETAILS

Whether Post Mortem Done		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hospital Name with Address			
Date of Post Mortem		Time	
Post Mortem Done By Forensic Medicine Officer:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, Mention The Doctor Reg No:			

DETAILS OF NOMINEE

Nominee Name :			
Relation With Insured		Date Of Birth	Age
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Address:	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary
Door No	Street Name		
Taluk	District/City	State	
Pincode	Contact No :	Email Id	
If Nominee Is Minor, Kindly Provide The Legal Guardian Details			
Name Of Guardian		Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship With Insured		Address <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	
Door No	Street Name		
Taluk	District/City		
State	Pincode		
Nominee Signature/Thumb Impression		Date	

Declaration:

I/We hereby to the best of my/our knowledge and belief, warrant the truth of the above details in every respect. I/ We agree that if we have made already or if I/We make in any of my/our further statements in respect of the said incident any false or fraudulent declarations or suppress or conceal any material fact, the Policy shall be void and all rights of compensation in respect of the present or future accident shall be forfeited.

MEDICAL CERTIFICATE (TO BE FILLED BY REGISTERED DOCTOR)

Name Of Insured		Age		Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Current Address						
Hospital Name with address						
Cause Of Accident :						

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Injuries were due to accident	<input type="checkbox"/> Yes <input type="checkbox"/> No
Insured Have Any Medical History	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes,	
At the time of accident insured was under influence of drugs / alcohol / intoxicants?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes,	

DETAILS OF DISABILITY

Permanent Total Disablement	
Loss Of	Percentage Of Disability
Permanent Partial Disablement	
Loss Of	Percentage Of Disability
Temporary Total Disablement	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes,	
To Whom It May Concern	
<p>I, Dr. After careful personal examination of the case hereby certify that shri/smt./ms. (name & designation of applicant) of the office of the whose signature is given above is suffering from And, therefore, I consider, that a period of absence from duty fromto With effect from is absolutely necessary for the restoration of his/her health.</p>	
Date of fitness to resume duty:	
I certify that I have examined the above named insured, the above statements are correct.	
Hospital Name:	Name Of Examined Doctor
Qualification	Reg No
Date	Signature with Seal

PAYABLE TO NOMINEE

Bank Name	Account Holder Name
Account No	IFSC Code
MICR No	Pan No.
Bank Branch	

CLAIM DOCUMENTS CHECK LIST

For Death Claim		For Permanent Total Disablement, Permanent Partial Disablement, Accident Weekly Benefit, Broken Bones	
1	Filled Claim form	1	Filled Claim form
2	First Aid treatment records	2	First Aid treatment records
3	Medicolegal Certificate	3	Indoor case papers (if hospitalized)

Address to dispatch the claim documents: **CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED**

HAT Claim Office: New No. 319, Old No. 154, Shaw Wallace Building, 2nd Floor, Thambu Chetty Street, Chennai - 600001. T: +91 (0) 44 4044 5400

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4	Indoor case papers (if hospitalized)	4	Discharge Summary
5	Copy of driving License	5	Consultation papers
6	FIR Copy	6	Medicolegal Certificate
7	Post Mortem Report	7	Fitness Certificate
8	Death Certificate	8	All original Medical bills, Final bill & paid receipts, Final bill breakup, Medicine Breakup
9	Payee Neft documents	9	OPD treatment/follow up records from date of an accident to till fitness
10	Insured KYC documents	10	Settlement letter from other insurance company (if claimed any Mediclaim)
11	Nominee ID proofs	11	Full photograph of the insured (After the accident) & Snap shot of injured spot
12	Final report from the police	12	Employee ID card/Student ID card
13	Viscera report	13	Payee Neft details (Insured or claimant)
14	Spot panchanama	14	KYC documents
15	Inquest panchanama	15	HR Leave certificate along with attendance register during leave periods
		16	Driving License (if RTA)
		17	FIR Copy/GD/Panchanama
		18	X-Ray films with reports/MRI Scan reports
		19	Last three month payslip (Prior to an accident)
		20	Disability certificate from civil surgeon (for disability claim)
		21	Written statement about the accident (When, where & How)

Loan Protection cover		For Motor PA Death Claim	
In addition to documents required in case of Death or Permanent Total disability.		1	Filled Claim form
1	Outstanding Loan Statement for a period of 6 months which includes date of accident.	2	First Aid treatment records
2	Monthly EMI statement from lender/s	3	Medicolegal Certificate
Modification of Residential Accommodation and Vehicle		4	Indoor case papers (if hospitalized)
In addition to documents required in case of Permanent Total disability		5	Copy of driving License
1	Full photograph of resident/vehicle	6	FIR Copy
2	Photos of before and after modified location	7	Post Mortem Report
3	Original bills for modification	8	Death Certificate
4	RC copy & vehicle insurance copy	9	Payee Neft documents
Educational Benefit/Girl Child Marriage Grant		10	Insured KYC documents
In addition to documents required in case of Death or Permanent Total disability.		11	Nominee ID proofs
1	Birth Certificate/age proof of the child / children	12	Final report from the police
2	Bonafide student certificate from the school where the child is studying for educational benefit	13	Viscera report
3	Affidavit for Marriage status – for Girl Child Marriage Grant	14	Spot panchanama
		15	Inquest panchanama
		16	Indemnity Bond (100 RS stamp paper)
		17	Affidavit (100 RS stamp paper)
		18	Legal heir certificate
		19	Family Card
		20	RC Copy
		21	Policy copy

Address to dispatch the claim documents: **CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED**

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