ODISHA POWER TRANSMISSION CORPORATION LIMITED

(A Government of Odisha Undertaking)

Regd. Office: Janpath, Bhubaneswar-751022, Odisha

No.AW-E&M-V-33/2013/ 13650 Date: 29/7/13

CIRCULAR

Sub: Renewal of Group Personal Accident Policy.

The Group Personal Accident Insurance Policy covering all the employees of OPTCL/GRIDCO has been renewed for a period of one year with effect from **00.00 Hrs. of 17.7.2013 to midnight of 16.7.2014** with the The Oriental Insurance Company Limited under the **Policy No.345100/48/2014/277**. The Board of Directors in their 57th meeting held on 1st June 2013 decided to enhance the existing sum assured under the **GPA scheme from Rs.6 lakhs to Rs.15 lakhs for Non-Exectives and from Rs.10 lakhs to Rs.25 lakhs for Executives in case of death, total permanent disablement and total partial disablement arising out of accident.**

However the period from **6.5.2013 to 16.7.2013**, the insured amount is **Rs. 6 lakhs for Non-Executives and Rs 10 lakhs for Executives in case of death, total permanent disablement and total partial disablement arising out of accident and the policy no. for the said period is 345100/48/2014/77.**

Following are the features of the policy. (**For the period 00.00 Hrs. 17.7.2013 to midnight of 16.7.2014):**

A. The insured sum payable by the insurer is **Rs.25,00,000/- (Rupees Twenty Five lakhs) for Executives and Rs.15,00,000/- (Rupees Fifteen lakhs) for the Non-Executives.** The insured amount becomes payable to the legal heirs/nominee of a deceased employee of OPTCL/GRIDCO in case of death due to ACCIDENT only (death resulting solely and directly from accident caused by external violent and visible means) and to the employee in case of total permanent disablement and total partial disablement arising out of accident.

B. As per the terms of the Insurance Policy death on account of the following reasons are excluded from the purview of the policy.

(a) Intentional self-injury, suicide, an attempted suicide, venereal disease or insanity.
(b) Whilst under the influence of intoxicating liquor or drugs.
(c) Whilst engaging in aviation activities other than traveling as a bonafide passenger.
(d) Arising or resulting from the insured committing any breach of the law with criminal intent.
(e) War and allied risks. Nuclear perils.
(f) Death/disablement resulting directly or indirectly caused by childbirth or pregnancy.

TABLE OF BENEFITS.

Benefit No.	Description	Percentage
1	Death only	100% of sum insured
2	Loss of Two limbs, Two Eyes or one limb and one Eye	100% of sum insured
3	Loss of One limb or one Eye	50% of sum insured
4	Permanent Total Disablement from injuries other than named above (P.T.D.)	100% of sum insured
5	Permanent Partial Disablement	..... % as per schedule of the policy

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The Insurance Company shall pay the Insured employee to the extent and in the manner hereinafter provided that if any of the insured person shall:

1. Sustain any bodily injury resulting solely and directly from accident caused by external violent and visible means, then the company shall pay to the insured or his legal personal representative(s) as the case may be the sum or sums hereinafter set forth in respect of any of the insured persons specified in the schedule:-

(a) If such injury shall within twelve calendar months of its occurrence be the sole and direct cause to the death of the insured persons, the Capital sum insured stated in the schedule hereto applicable to such insured person.

(b) If such injury shall within twelve months of its occurrence be the sole and direct cause of the total and irrecoverable loss of:-

i) Sight of both eyes, or the actual loss by physical separation of two entire hands or two entire feet, or one entire hand and one entire foot or of such loss of sight of one eye and such loss of one entire hand or loss of one entire foot, the capital sum insured stated in the Schedule hereto applicable to such insured person.

ii) Use of two hands or two feet, or of one hand and one foot or of such loss of sight of one eye and such loss of use of one hand or one foot, the capital sum insured stated in the schedule hereto.

c) If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of the total and irrecoverable loss of:

i) The sight of one eye or of the actual loss by physical separation of one entire hand or one entire foot, fifty percent (50%) of the capital sum insured stated in the schedule hereto applicable to such insured person.

ii) Total and irrecoverable loss of use of a hand or a foot without physical separation, fifty percent (50%) of the capital sum insured stated in the schedule hereto applicable to such insured person.

Note: For the purpose of clause (b) and (c) above, physical separation of a hand or feet means separation of hands at or above the wrist and or of the foot at or above the ankle.

d) If such injury shall as a direct consequence thereof immediately permanently totally and absolutely disable the insured person from engaging in any employment or occupation of any description whatsoever, then a lump sum equal to hundred percent(100%) of the capital sum insured stated in the schedule hereto applicable to such insured person.

e) If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of the total and/or partial irrecoverable loss of use or the actual loss by physical separation of the following then the percentage of the Capital Sum insured applicable to such insured person in the manner indicated below:

		Percentage of capital sum insured.
i.	Loss of toes – all	20
	Both Great phalanges	5
	One Great phalanx	2
	Other than great if more than on toe lost each	1
ii.	Loss of hearing – both ears	50
iii.	Loss of hearing one ear	15
iv.	Loss of four fingers and thumb of one hand	40
v.	Loss of four fingers	35
vi.	Loss of thumb -	
	both phalanges	25
	one phalanx	10
vii.	Loss of Index finger	
	three phalanges	10
	two phalanges	8
	one phalanx	4
viii	Loss of middle finger	
	three phalanges	6
	two phalanges	4
	one phalanx	2
ix.	Loss little finger	
	three phalanges	5
	two phalanges	4
	one phalanx	2
x.	Loss of little finger	
	Three phalanges	4
	Two phalanges	3
	One phalanx	2
xi	Loss of Metacarpals	
	first or second(additional)	3
	third, fourth or fifth(additional)	2
xii.	Any other permanent partial disablement	% as assessed by the Doctor

CONDITIONS

1. Upon the happening of any event, which may give rise to claim under this Policy, written notice with full particulars must, be given to the company immediately. In case of death, written notice also of the death must unless reasonable cause is shown, be so given before internment, cremation and in any case, within one calendar month after the death, and in the event of loss of sight or amputation of limbs, written notice thereof must also be given within one calendar month after such loss of a sight or amputation.

2. Satisfactory proof to the Company shall be furnished of all matter upon which a claim is based. Any medical or other agent of the Company shall be allowed to examine the Persons insured on the occasion of any alleged injury or disablement when and so often as the same may reasonably be required on behalf of the company and in the event of death to make a post-mortem examination of the body of the insured persons. Such evidence as the company may from time to time require shall be furnished and a post-mortem examination report if necessary be furnished within the space of fourteen days after demand in writing and in the event of claim in respect of loss of sight of the insured person(s) shall undergo at the insured's expense such operation or treatment as the company may reasonably deem desirable.

No sum payable under this policy shall carry interest.

3. The Company shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent statement or device, whether by the insured or by any person on behalf of the insured persons.

4. The assignee/nominee in such an event shall be the nominee nominated by the employee for this Scheme failing which the nominee under the GRIDCO/OPTCL PF Trust shall be applicable. In case there is no nomination in either of above cases, the payment is to be made to the legal representative as identified by a probate/Will/Letter of Administration/Succession Certificate issued by the Court and subsequent certification by GRIDCO/OPTCL.

EXCLUSIONS

1. No employee while working on High Voltage transmission lines should be allowed to work if he/she is under the influence of alcohol or any intoxicating drugs/substance as this is a specific exclusion under the policy.

2. No employee while working on High voltage transmission lines should be allowed to work if he/she is not equipped with prescribed protective gear like gloves/helmet etc. if any, required as per the safety manual/guideline of the organization as this is also a specific exclusion under the policy.

CLAIM PROCEDURE

(A) **In case of claim arising out of accidental death/total permanent disablement/total partial disablement and upon the receipt of such information, the Head of office, under whose control the employee was/is working shall make a telephonic intimation to The Oriental Insurance Company Limited on Phone no. 0674-2415287/0674-2415159, Fax no. 0671-2423471 as well as to DGM (HRD) E&M, OPTCL on mobile number 9438907036 immediately (maximum within 24 hours) followed by a detailed notice in the format given at Annexure-A within 7 days to Sr. Divisional Manager, The Oriental Insurance Company Limited Mangalam Nivas (2nd floor), In front of HDFC Bank, Bajrakabati Road, Cuttack-753001.**

A copy of the intimation letter should also be sent to DGM.(HRD)-E&M, OPTCL. Hqrs. Office, Bhubaneswar.

Immediately after serving the notice, the Head of Office will send a claim form (Annexure-B) to the employee/ nominee of the deceased employee and advise him/her to submit the claim form in his office duly filled in along with the following:

1. Death certificate
2. Post mortem report
3. FIR at Police or Panchanama, final police investigation report.
4. Any other relevant documents.

The Head of Office shall arrange to submit the claim form received from the employee/ nominee along with a certificate mentioning the following to the Sr. Divisional Manager, The Oriental Insurance Company Limited Mangalam Nivas (2nd floor), In front of HDFC Bank, Bajrakabati Road, Cuttack-753001 on behalf of the employee/nominee:

1. Name of the deceased employee
2. Designation and employee code No.
3. Date of enrolment, date of entry into the present post

4. Place of posting and previous month salary slip

On submission of the claim form intimation should be sent to the Dy. General Manager (HRD) - E&M to expedite settlement of the claim.

For any queries and clarifications the Head of Office may contact the Sr. Divisional Manager, The Oriental Insurance Company Limited and Dy. General Manager, (HRD) – E&M.

NOTE : ***<u>The GPA assistance is in addition to the financial assistance payable to the employees under Rehabilitation Assistance Regulation, 1977 and other compensation/assistance payable under any law/scheme/regulations in the event of death of an employee.</u>***

<u>APPLICABILITY</u>

The employees covered under this policy includes all the functional Directors of OPTCL/GRIDCO, all the full time regular employees of OPTCL/GRIDCO (including those on probation pending confirmation of appointment), all the employees of OPTCL/GRIDCO on deputation to other organizations. The employee shall not include Nominal Muster Roll staff or casual laborers of employees of Statement Government or other organizations deputed to OPTCL/GRIDCO on foreign service terms.

29/7/2013

DEPUTY GENERAL MANAGER (HRD)-E&M

Memo No. 13651(100) / Dated,the 29/7/13

Copy to all Chief General Manager / Sr. General Managers / Sr.G.M (P.S), SLDC / Company Secretary of OPTCL / General Managers / Deputy General Managers / Asst. General Managers / Managers / Asst. Company Secretary of Gridco / S.E (Civil) / Medical Officer, Power Hospital / Liaison Officer, Calcutta / New-Delhi / D.D.O. OPTCL Hd.qrs. They are requested to display this circular in the Notice Boards and also circulate it to all the Officers and Employees under their control for their information and necessary action.

29/7/2013

DEPUTY GENERAL MANAGER (HRD)-E&M

Memo No. 13652(5) /Dated,the 29/7/13

Copy to Sr. P.S. to C.M.D / Sr. P.S. / P.S. to all Directors of OPTCL/GRIDCO for kind information.

29/7/2013

DEPUTY GENERAL MANAGER (HRD)-E&M

Memo No. 13653 /Dated,the 29/7/13

Copy to CGM (IT). He is requested to upload the Circular in OPTCL website.

29/7/2013

DEPUTY GENERAL MANAGER (HRD)-E&M

(Annexure-A)

G.P.A. Notice form

(A) (a) Name and Designation of the employee.

(b) Employee number

(c) Father's Name

(d) Place of posting

(e) Cause of death/Disablement

(f) Policy No. **345100/48/2014/277**

Period of Insurance: **00.00 Hrs. of 17.7.2013 to midnight of 16.7.2014**

Policy No. **345100/48/2014/77**

Period of Insurance: **00.00 Hrs. of 6.5.2013 to midnight of 16.7.2013**

(Please tick whichever is applicable)

Signature of Head of Office

व्यक्तिगत दुर्घटना क्लेम फार्म/PERSONAL ACCIDENT CLAIM FORM

दि ओरिएण्टल इन्श्योरेन्स कम्पनी लिमिटेड

The Oriental Insurance Company Limited

(भारत में निगमित भारतीय साधारण बीमा निगम की सहायक कम्पनी)

Incorporated in India—Subsidiary of General Insurance Corporation of India

पंजीकृत कार्यालय: "ओरिएण्टल हाउस" ए-25/27, आसफ अली रोड, नई दिल्ली--110002

Regd. Office : "ORIENTAL HOUSE" A-25/27, Asaf Ali Road, New Delhi - 110002

फार्म को देने मात्र से कम्पनी दावे की देयता स्वीकार नहीं करती। प्राप्ति के सात दिन के अन्दर यह फार्म पूर्णत: भर कर लौटाया जाए। दावेदार के खर्चे पर पिछले पृष्ठ पर दी गई मेडिकल रिपोर्ट भरवाकर भेजी जाए। इसके बिना कोई क्लेम स्वीकार नहीं किया जाएगा।

This form is issued without admission of liability' and must be completed and returned within seven days after its receipt. No claim can be admitted unless a medical overleaf be furnished at the expense of the claimant.

क्लेम नं०/Claim No. A_____	पालिसी नं०/Policy No._____
1. पूरा नाम/Name in full_____ निवास/Residence _____ व्यापार का पता/Business Address_____ व्यापार अथवा व्यवसाय का पता यदि एक से अधिक हो तो सभी का विवरण दें। Permanent Business or Occupation if more than one state all	वर्तमान आयु/Present Age _____वर्ष/Years कद . फुट इंच Height_____ft._____in. वजन स्टोन पौंड Wt._____st._____lbs.
2. (क) दुर्घटना कब हुई ? दिन, तारीख व समय लिखें (a) When did accident occur ? State day, date and hour (ख) दुर्घटना कहां हुई ? (b) Where did it occur ? (ग) दुर्घटना के कारण व चोटों का विवरण दें (c) Give full particulars of the cause and the injuries sustained	
3. दुर्घटना के गवाह का नाम व पता लिखें Give name and address of the witness of the accident	
4. (क) डाक्टरों, जिहोंने आपकी चिकित्सा की, के नाम व पता लिखें। (a) Give name and address of the Doctors who attended you (ख) अपने व्यक्तिगत चिकित्सक का नाम व पता लिखें (b) Name and address of your Ordinary Medical Attendant	
5 कृपया बतायें कि आवश्यकता पड़ने पर कोई चिकित्सक अथवा कम्पनी का अन्य अधिकारी आपसे कब व कहाँ मिल सकता है। State When and where a Medical or other Officer of the Company can visit you, if necessary.	

6. (क) कृपया बताएँ कि चोट लगने के एकमात्र व प्रत्यक्ष कारण से आपको बिस्तर अथवा घर पर कितने दिन तक अनिवार्यतः व पूर्णतः रुकना पड़ा : (a) State the number of days you have been necessarily and entirely confined to bed Room or House as the sole and direct result of the injuries sustained.	बिस्तर में अथवा घर में TO BED OR ROOM	घर में TO HOUSE
	दिन तक for_____days से तक from_____ to _____ (दोनों तारीख शामिल करते हुए) (Both Inclusive)	दिन तक for_____days से तक from_____ to _____ (दोनों तारीख शामिल करते हुए) (Both Inclusive)
(ख) यदि आप अभी भी इसी हालत में हैं तो उपरोक्त दोनों में से किस स्थिति में हैं । (b) If still confined to any, state which	ब (b)	
(ग) क्या आप ने उपरोक्त अवधि के दौरान अपना व्यवसाय किया है अथवा कारोबार देखा है। (c) Have you in any way attended to business or work during the above period.	स (c)	
(घ) क्या आप अपने व्यापार अथवा व्यवसाय को अंशतः देखने की स्थिति में हैं ? यदि हाँ तो किस तारीख से (d) Have you been able to attend to any Portion of your business or occupation and if so, from what date ?	द (d)	
7. क्या आपने इससे पूर्व किसी दुर्घटना तथा/ अथवा बीमारी पालिसी के अन्तर्गत कोई क्लेम किया है अथवा क्षतिपूर्ति प्राप्त की है ? Have you previously claimed or received compensation under an Accident and/or Sickness Policy ? If so, please give particulars.		
8. (क) क्या आपने कहीं और भी बीमा कराया हुआ है । (a) Are you insured elsewhere ?	a)	
(ख) यदि हाँ तो प्रत्येक कम्पनी अथवा बीमाकर्ता का नाम लिखें। यह भी बताएँ कि आप कितनी राशि तक क्लेम करने के हकदार हैं । (b) If so, give the name of each company or insurer and amount you are entitled to claim.	b)	

मैं एतद्द्वारा घोषणा करता हूं कि उपरोक्त चोटें मुझे लगी हैं व मैं उपर्युक्त विवरणी की पूर्ण सत्यता का वचन देता हूं तथा इस बात की सहमति देता हूँ कि यदि मैंने कोई मिथ्या विवरण दिया है / दूंगा अथवा किसी तथ्य को दबाया या छिपाया है / दबाऊंगा / छिपाऊंगा तो क्षतिपूर्ति के अधिकार से पूर्णतः वंचित हो जाऊँगा ।

I HEREBY DECLARE that I have received the injuries above described, and warrant the truth of foregoing particulars in every respect, and I agree that I have made, or if shall make false or untrue statement, suppression or consealment my right to compensation shall be absolutely forfeited.

मैं .....रु०....प्रति सप्ताह अथवा .....रु० की कुल राशि, जो मुझे कंपनी पर मेरे क्लेम के एवज में पूर्ण निपटान के रुप में स्वीकार है, मुझे अदा किए जाने का दावा करता हूँ ।

I claim to be paid sum of_____ per week, or the total sum of _____ which I agree to accept in full settlement of my claim on the company.

दिनांक/Date_____ हस्ताक्षर/Signature_____

प्राइवेट व गोपनीय/PRIVATE & CONFIDENTIAL

मेडिकल रिपोर्ट/MEDICAL REPORT

दि ओरिएण्टल इन्श्योरेन्स कम्पनी लिमिटेड

The Oriental Insurance Company Limited

(भारत में निगमित भारतीय साधारण बीमा निगम की सहायक कम्पनी)

Incorporated in India–Subsidiary of General Insurance Corporation of India

पंजीकृत कार्यालय: "ओरिएण्टल हाउस" ए-25/27, आसफ अली रोड, नई दिल्ली--110002

Regd. Office : "ORIENTAL HOUSE" A-25/27, Asaf Ali Road, New Delhi-110002

नोट : यह फार्म दावेदार के चिकित्सक द्वारा विधिवत् व पूर्णतः भरा जाये ।

NOTE : This form is to be completed by the claimant's Medical Attendent whose replies should be as full as possible.

पालिसी नं०/Policy No. _____	क्लेम नं०/Claim No. A _____
1. दावेदार का पूरा नाम / CLAIMANT-Name in full _____ आयु/Age _____	
2. चोट की प्रकृति व प्रसार (यदि एक हाथ या एक पैर को चोट आई हो तो लिखे दाँया है या बाँया The nature and extent of injuries (if to a limb, state whether right or left)	
3. आपकी जानकारी के अनुसार दुर्घटना का कारण The cause of the accident, so far as known to you.	
4. (क) चोट लगने के फलस्वरुप आपने दावेदार की सर्वप्रथम कब चिकित्सा की ? (a) Date of your first attendance upon him in consequence of the injuries sustained. (ख) क्या आप दावेदार का इलाज अब भी कर रहे हैं ? (b) Are you still in attendance ?	(क) (a) (ख) (b)
5. क्या आप दावेदार के व्यक्तिगत चिकित्सक हैं? यदि हाँ, तो आप उसे कब से जानते हैं तथा आपने उसके किस रोग का इलाज किया ? Are you his usual Medical Attendant and if so, how long have you known him and for what have you attended him ?	
6. (क) क्या इसकी चोट के लक्षण (i) केवल दुर्घटना के फलस्वरुप हैं अथवा (ii) किसी बीमारी या अन्य कारण के फलस्वरुप हैं । (a) Are his symptoms (i) due exclusively to the accident or (ii) traceable to disease infirmity or any other cause ? (ख) क्या वह अभी " थक्का जमने" गठिया, मधुमेह अथवा दौरा पड़ने आदि बीमारियों से पीड़ित रहा है। (a) Has he ever suffered from Gout, Rheumatism Diabetes or Fits ?	(क) (i) (ii) (i) (ii) (ख) (b)

(ग) क्या उसकी मेडिकल हिस्ट्री के अनुसार कोई ऐसा तथ्य जो प्रत्यक्षत: या परोक्षत: इस दुर्घटना का कारण रहा हो अथवा दावेदार के स्वास्थ्य लाभ में बाधक सिद्ध हो ? (c) Is there anything in his medical history which may have contributed directly or indirectly to the accident, or which may likely to retard his recovery ?	(ग) (c)
(घ) आपके मतानुसार क्या वह किसी नशीली वस्तु के प्रभाव में था ? यदि हाँ, तो इसका आधार बतायें (d) Have you any reason to suppose that he was under the in influence intoxicants at the time of the accident ?	(घ) (d)

	बिस्तर मे अथवा घर मे TO BED OR ROOM	घर मे TO HOUSE
7. अपनी जानकारी के आधार पर वह अवधि बतायें जिसके दौरान दावेदार को चोटग्रस्त होने के प्रत्यक्ष व एकमात्र कारण स्वरुप अनिवार्यत: बिस्तर पर अथवा घर में ठहरना पड़ रहा हो। यदि वह अब भी उसी हालत में है तो बतायें कि बिस्तर पर है अथवा 'घर पर' रहने की स्थिति में है तथा ऐसी अवस्था में अभी और कितने समय तक रहना पडेगा ? State the time within your own knowledge that the Claimant has been, as the direct and sole consequence of the Injuries sustained, necessarily confined to his bed-room or house. If still so confined state to which and the probable duration of confinement to bed or house.	दिन तक for_____days से तक from_____ to _____ (दोनो तारीख शामिल करते हुए) (Both inclusive)	दिन तक for_____days से तक from_____ to _____ (दोनो तारीख शामिल करते हुए) (Both inclusive)

(8) (क) क्या वह अपने व्यापार या व्यवसाय को अटैंड करने की हालत में है ? (a) Has he been able to attend any portion of his business or occupation ? (ख) यदि हाँ तो किस तारीख से ? (b) If so from what date ? (ग) यदि नहीं तो बतायें (c) If not, please state, probable date (i) कि वे किस तारीख तक इस काबिल हो जायेंगे। (i) of his being so able (ii) किस तारीख तक पूर्ण स्वस्थ हो जायेंगे (ii) or his complete recovery	(क) (a) (ख) (b) (ग) (c) (i) (ii)
9. क्या इस समय भी वे अक्षम (डिसएबल) है ? यदि नहीं तो कृपया पूर्णत: स्वस्थ होने की तारीख बतायें. Is there now any disability ? If not, please give date of recovery.	
10. कोई अन्य टिप्पणी Any further remarks	

मैं एतद्द्वारा प्रमाणित करता हूं कि ऊपरोक्त व्यक्ति ऊपर दी गई दुर्घटना का शिकार हुआ, तथा इस रिपोर्ट मे दिए गए सभी विवरण सही है.
I hereby certify that the aboved named met with the accident refered and that the foregoing statements are correct

हस्ताक्षर/Signature_____ योग्यता /Qualification_____

पता / Address _____ तिथि / date_____

पूर्ण अक्षमता से तात्पर्य है : जब बीमाकृत व्यक्ति अपने व्यापार / व्यवसाय को करने के लिए पूर्णत: अयोग्य (अक्षम) हो जाये.
आंशिक अक्षमता से तात्पर्य है : जब वह इसे करने के लिए आंशिक रुप से अक्षम (अयोग्य) हो जाए।
TOTAL DISABLEMENT occurs when the Insured is wholly prevented from attending to his business occupation.
PARTIAL DISABLEMENT when prevented from attending to substantial portion thereof.

Manager (HRD)
Roozelin Bisoyi