

APPLICATION FORM FOR ACCIDENTAL DISABILITY CLAIM - CLAIMANTS STATEMENT

(To be filled in by the person legally entitled to the policy money. All the details sought for must be furnished and must be clear & unambiguous)

Policy Number (s)	:										
Date	:	D D M M Y Y Y Y									
I. Information about the Claimant (if different from Life Assured)											
1 a) Name of the Claimant	: 1)										
	2)										
b) Complete Address & Tel. No.	:										
c) Age of Claimant (In Years)	:										
d) Relationship of the Claimant to the Deceased	:	Parent Spouse Son/ Daughter									
e) Bank Details (Mandatory - (The Claimant show	ıld bo a l	Others (Specify)									
e) Bank Details (Mandatory - (The Claimant shown Bank Name	: :										
Bank Account No	:										
Contact No of the Bank	:										
Address of the Bank	:										
II. Information about the Life Assured and Accid	lent										
2 a) Name	:										
Age (at the time of disability)	:										
b) Date of Accident	:	D									
c) Place of Accident	:										
d) Time of Accident	:										
3 a) Last Employer's name and address											
3 dy East Employer 3 hame and address	•										
13. 5											
b) Designation	:										
4 Last residential address	:										
a) How did the accident occur?	:										
b) People involved in the accident	:										
c) Details of disability/ Dismemberment	:										
Physical impairment area Nature of in											
(Limbs, Eyes etc) (Permanent/	rempor	rary) impairment (# of days) hospitalization?									
d) Name and address of Police Station where	:										
FIR was lodged (Please furnish a copy of the F	IK)										
e) FIR No.	:	f) Tel.:									
5) Name and address of Hospital (where last	•										
/current treatment was/ is conducted)	•										

6)	Did the Life Assured sur or recurrent health prol	olems?	: Y	es	No						
	If yes, please furnish the	e details below.									
	I) Nature of illness/	ailment/ disorder	:								
	II) Duration of illness	/ ailment/ disorder	:								
		or/ hospital where the created for the same	:				<u> </u>				
7)	Name & Addresses of the Doctor/ Hospital(s) who treated him / her during the last three years & the ailments treated by the										
.,	Name of the	Address	Contact N			consultation	Disease/ Condition				
	Doctor/ Hospital	Addiess	Contact is			mission	Disease/ Colldition				
0)	Darticulars of other Life	Incurance / Madiclaim	nolicies hold by t		N caurad						
8)	Particulars of other Life Policy Details	Policy 1	Policy 2	le Lile A		licy 3	Policy 4				
	Policy Number	1 oney 1	1 oney 2		10	110, 5	Policy 4				
	Name of the Company										
	Commencement Date										
	Sum Assured										
	Riders										
	Year of Claim										
	Cause of Claim			\longrightarrow							
	Amount Claimed			\bot							
9)	Any other information, would be vital in the claunder this policy?		:								
III. De	eclaration And Authoriz	ation									
acceptance of the same by the Company shall not constitute an admission by the Company that there was any insurance in force on the life in question or a waiver of any rights or defence. Notwithstanding, any law, custom or usage, prohibiting the furnishing of secret information obtained during the medical treatment / investigation of Life Insured, I/We hereby authorize any doctor or other person, or any hospital, sanatorium, medical professional, hospital or other medical care institution, insurance support organization, pharmacy, governmental agency, insurance company, employer, benefit plan administrator accountant, or financial adviser or other entity to provide to AEGON RELIGARE LIFE INSURANCE COMPANY LTD., any of its offices, or Court of Law, or any investigative agency of the said Company acting on its behalf, information concerning employment, finances or insurance, advice, care or treatment provided to deceased, or any information that may be required concerning the health of the deceased (Life Insured) including information relating to mental illness, use of drugs, use of alcohol, HIV(AIDS Virus) and /or sexually transmitted diseases. A Photostat copy of this authorization shall be considered as effective and valid as the original. Signature of Claimant (No.1)											
	d at		e) Date								
-	ature of Witness - Mand	•									
	ess:										
							Signat	ure:			
(3) Blo	orm must be witnessed ock Development officer, (4) of Manager, (6) A Gazetted C	A Bank Manager of a Nat	ionalized bank with	Rubber	Stamp, (5)	An officer of t					
	ration in case of an illitera ing unconnected with the					ession should l	be made l	oy a per	rson of		
"I here	eby certify that the contents e/she has affixed his/her th	s of above form have been	explained by me to	the Claim	nant in the				imant and		
Name	e: :										
∆ddr/	·				·						
Addit	1										
						(Full Si	gnature (of the V	Witness)		
 CI M Pr 	ment Checklist aimants Statement edical Attendant Certific oof of Age (if not submit ost Mortem report - Duly	tted earlier	eath)	6. Con: 7. Orig	sent lette ginal Polic	for accident r duly signed y document ificate confirr		bility			
f	All payments shall be m for further evidence ned Acceptance of forms do	eded to process the cla	aim and to enter				retains t	he righ	nt to call		