Claimant's Statement For Disability Claim

We draw your attention to below points which will help us in faster claim settlement:

- This form is to be filled completely and answers must be clear & unambiguous. Incomplete form(s) will not be accepted.
- All answers should be responded in bold capital letters. Please avoid overwriting and any change in statement/ ink must be countersigned by the Life Assured.
- Claim processing will be initiated only post receipt of all mandatory documents along with completely Claimant Statement for Disability Form.
- Submission of this form will not be construed as acceptance of claim by the company. The Company reserves the right to call for additional document/ requirements.

A. Documents to be submitted:

Mandatory Requirements:

1) Completely filled Claimant statement for Disability Rider form Part A (to be filled by Life Assured/Claimant) & B (To be filled by Attending physician), Continuous Disability statement, Certificate by Employer.
2) Medical Records (admission notes, discharge Summary, all Investigation reports supporting to diagnosis.)
3) First information Report / MLC copy
4) Driving license(in case the Life Assured was driving)
5) Cancelled cheque/ copy of passbook detailing account information for Electronic payment.
6) KYC Document of life Assured

Who is this contact person? what is the relationship with the LI and the Group policyholder:

Name:_____ Cell No. ☐☐☐☐☐☐☐☐☐☐

Tel No. ☐☐☐☐☐☐☐☐☐☐ Fax No. ☐☐☐☐☐☐☐☐☐☐

1. Claimant Details:

a) Policy Number: ☐☐☐☐☐☐☐☐☐☐☐☐

b) Name of Claimant: Surname: _____ First Name _____

c) Name of the group policyholder: _____

c) Date of birth: ☐☐☐☐☐☐☐☐ Permanent Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐

d) Residential Address: _____

_____

f) Mobile No. ☐☐☐☐☐☐☐☐☐☐ Email ID_____ Aadhar No. ☐☐☐☐☐☐☐☐☐☐☐☐

g) What is the highest academic, professional or trade qualifications?

h) Personal Status (Please tick appropriate block)

Married ☐ Single ☐ Divorced ☐ Widow/widower ☐

If married please state occupation of spouse: _____

2. Particulars of present occupation: (Also applicable to self-employed)

a) Name and Address of last/present employer:

b) Length of service with employer:

c) What was your full-time occupation immediately before your current disability / impairment began?

d) Breakdown of duties

ADMINISTRATIVE %	SUPERVISORY %	MANUAL %	TRAVEL %

e) Give an accurate description of the exact duties and nature of your full time occupation (job description):

f) Is the aforementioned your nominated occupation and if yes how long have you been following this occupation?

g) State particulars of any hobbies or other occupations:

h) Occupations held in the past 10 years:

NATURE OF OCCUPATION AND EMPLOYER	DATE		DATE	
	From	D D M M Y Y Y Y	To	D D M M Y Y Y Y

i) On what date were you last able to undertake any part of the duties of your occupation?

j) When do you expect to return to work?

k) i) Have you been offered or enquired about any alternative occupation for remuneration by your employer? ☐ Yes ☐ No

If "yes" describe duties of alternative occupation offered:

ii) Have you accepted the alternate occupation offered? ☐ Yes ☐ No

If "yes" when do you expect to follow the alternative occupation?

On full time basis _____ On full time basis _____

iii) What is your expected remuneration? _____

3. a) Are you a smoker? ☐ Yes ☐ No If "yes" how many per day? ☐☐

b) Do you consume alcohol? ☐ Yes ☐ No

If "yes" what do you drink and the quantity consumed?

4. Information relating to your impairment

a) Nature of disability / impairment (s): _____

b) Indicate if your impairment (s) / disability are due to (please tick appropriate block)

Accident / Trauma ☐ Disease / Illness ☐

c) i) If the disability / impairment is a result of an accident, when, where, and how did the accident occur?

ii) Please furnish details of the relevant case number and the details of the police station at which the accident was reported.

d) If the disability / impairment is due to illness / disease please provide the following details:

i) Date the illness / disease was first diagnosed

ii) Name, address, contact no of all attending doctors

iii) What prescribed treatment are you currently taking / using?

iv) Name, address, contact no of your usual doctor during the last 5 years?

v) Have you been confined to: Bed / House / Hospital?

e) History of all medical consultation / treatment over last 5 years (treatments for flu and cold may be omitted)

Dates	Reasons	Treatment	Hospital / Doctor	Telephone No.
D D M M Y Y Y Y				

5. Information relating to your income

5.1 What was your taxable income for the past 12 months?

a) Commission earned during the past 12 months?

b) Directors Fees for the past 12 months?

5.2 a) Have you received any income since disablement? ☐ Yes ☐ No

If "yes" please state income amount for every month since disablement

b) Please provide details of the source of income:

5.3 a) Have you lodged or intend lodging a claim for payment of disability benefits with any other insurance company. If "yes" please furnish us with details.

Name of Insurance Co.	Policy Number	Date of Policy issue	Estimated Value
		D D M M Y Y Y Y	

c) Are you currently receiving any other benefits to supplement your income during your disability? ☐ Yes ☐ No

If "yes" please provide details

Electronic Funds Transfer (EFT) Mandate Form (Direct Transfer of funds to your bank account)

Account Holder Name: _____

(As mentioned in Bank Account)

Bank name: _____

Type of Bank Account: _____

Bank Account Number: | | | | | | | | | | | | | | | | | | | |

Branch Address: _____

MICR code: | | | | | | | | | | | |

(9 digit code as appearing on the cheque copy issued by bank)

IFSC code (Indian Financial Security code): | | | | | | | | | | | |

Note:

Please attach Pre Printed Cancelled Cheque bearing the above mentioned Account Number and IFSC Code along with this form. In case of non-availability of Pre Printed Cheque, ABSLI requires a bank statement or a Printed Bankers Authorization in original containing aforesaid details duly seal and signed by Bank Branch Manager

In case of submission of incomplete / incorrect form Company will not transfer the Claim Proceeds Electronically and provide an account payee cheque mentioning account number and bank name if provided in the mandate or else company will draw an account payee cheque in case of admissibility of claim.

Declaration:

I / We hereby

- Declare that the details provided as above are correct and complete.
- Authorize ABSLI to process the proceeds under the death claim of the aforesaid policy/s through EFT to the above mentioned account details
- Agree to not hold Aditya Birla Sun Life Insurance Company Limited or its associate / agent responsible in case of any non-credit to my bank account or if the transaction is delayed or not effected at all for reasons of error/ misrepresentation/incomplete/incorrect information furnished by me in this EFT mandate

Date: | D | D | M | M | Y | Y | Y | Y |

_____

Life Insured Assured's Signature

Declaration by Life Insured:

I hereby notify the Aditya Birla Sun Life Insurance Company Limited (ABSLI) that Mr./Ms./Master_____ whose life was insured by the said company, under group policy no. _____is/was suffering from the above mentioned disease/condition and hereby declare that the said person is the Life Insured described above and that the aforesaid answers and statements made by me are true and correct. I agree that furnishing of this form, or any forms supplemental thereto, shall not constitute nor be considered an admission of claim by Aditya Birla Sun Life Insurance Co. Ltd. that there was any assurance in force on the life in question or of its liability thereunder, nor a waiver of any of its rights or defense. I hereby authorize any physician, hospital, clinic, insurance company or other organization, institution or person, that has any record of the deceased or his health, to give to Aditya Birla Sun Life Insurance Company Limited, any and all information about the deceased with reference to his health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. I further authorize the Employers (past and present) of the Life Insured to furnish to Aditya Birla Sun Life Insurance Company Limited, details of the leave availed of by the Life Insured during the last three years of his service together with copies of the leave applications and medical certificates, if any, submitted by the Life Insured in support of such applications and details of reimbursement of medical expenses. I also consent to a personal investigation.

I agree that payment of claim amount shall constitute discharge of liability of ABSLI.

I hereby provide my consent to receive a call from ABSLI or its authorized Service Providers in connection with any matter related to the above policy.

_____

Signature of Life Insured (Member)

Date: | D | D | M | M | Y | Y | Y | Y |

Place: _____

Vernacular Declaration:

Declaration to be made by Third Person where the claimant signs in vernacular or affix a thumb impression or has not filled the form:

I hereby certify that the contents of this form were explained to the claimant in _____ language and have truthfully recorded the answers provided to me. The claimant has affixed his/her impression in my presence

Date: D D M M Y Y Y Y

Place: _____

_____

Declarant Name & Signature:

FOR/1/17-18/1280