Claimant's Statement for Accidental Disability Rider

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 of policy owner/ copy of passbook detailing account information for Electronic payment.
6) KYC Document of life Assured
7) Original policy document or Indemnity Bond in case policy document is lost

To be completed by the Life Assured/Claimant – Part A

Details of the Claimant, If other than Life Assured.

Name: _____ Relation to Life Assured: _____

DOB: D D M M Y Y Y Y KYC submitted: _____

E-mail: _____ Cell No.: _____

Pan No.: _____ Aadhar No.: _____

1. Life Assured Details:

a) Policy Number: _____ b) EIA Number: _____

c) Name of Life Insured: _____

d) Date of birth: D D M M Y Y Y Y Permanent Account Number (PAN): _____

e) 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: _____

1) What is the nature of dismemberment and which parts of the body have been affected?

_____

_____

2) Mention the date from which you had to be dismembered?

_____

_____

FOR/11/17-18/1258

3) State the names, address and contact no. of the doctor/s and the Hospital/s in which you were treated for the said dismemberment? Please attach relevant doctor certificates and Hospital admit/discharge card.

_____

_____

_____

4) Give a detailed description of the circumstances under which you were dismembered, mentioning date, time and place of accident which led to the said dismemberment?

_____

_____

_____

5) If the dismemberment arose as a result of an accident, name the Police Station where the accident was reported and also mention the case no/FIR. Attach a copy of the FIR and the Final Police Investigation Report certified by the police. If the accident was not reported to the police, please state the reasons thereof and mention the names, addresses and Telephone nos. of the persons who witnessed the accident and your relationship with them, if any.

_____

_____

_____

Declaration

I/We hereby notify Aditya Birla Sun Life Insurance Company Limited (ABSLI) that Mr./Ms./Master _____ whose life was insured by the said company, under policy no./ nos. _____ is dead and I 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 by Aditya Birla Sun Life Insurance Company Limited (ABSLI) that there was any assurance in force on the life in question or of its liability there under, 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 (ABSLI), 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 (ABSLI), 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 hereby provide my consent to receive a call from ABSLI or if authorised service provider in connection with any matter related to the above policy.

Date: D D M M Y Y Y Y Place: _____

Name of Claimant : _____

_____
Signature of First Claimant:

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: _____

_____
Declarant Signature

Electronic Funds Transfer (EFT) Mandate Form

(Direct Transfer of funds to your bank account)

Account Holder Name: _____
(As mentioned in Bank Account)

Bank Name: _____ Branch 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, BSLI 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 BSLI 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 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 Assured's Signature

Declaration by Life Insured:

I hereby notify the Aditya Birla Sun Life Insurance Co. Ltd. that Mr./Ms./Master_____ whose life is insured with ABSLI is suffering from_____. I hereby declare that the 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 my health, to give to Aditya Birla Sun Life Insurance Company Limited, any and all information about my 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.

Date: | D | D | M | M | Y | Y | Y | Y | Place: _____

_____
Signature of Life Insured

_____
Signature of Policy Owner

To be completed by Attending Physician – Part B

Policy Number: | | | | | | | | | | |

Name of Life Insured: _____

Date of Birth: D D M M Y Y Y Y Age: | |

Occupation (including description of duties): _____

Last day at work: _____ Qualification: _____

Date of Admission: D D M M Y Y Y Y Time of Admission: H H M M

MEDICAL HISTORY

1. Diagnosis and reason for claim: _____
2. Date when the symptoms started: _____
3. Date when Life Assured first seen by you for this reason: _____
4. Date when Life assured stopped work: _____
5. Date when life assured was seen by you for any other conditions (please give dates and details below): _____

_____

Date	Reason for Consultation	Treatment Prescribed	Duration of Complaint

MEDICAL REFERENCES

Please give the details of any other Practitioners, Specialists or Hospitals to who the claimant has been referred.
Please include copie of all available Specialist reports

Name of Practitioner / Hospital	
Speciality	
Postal Address & Contact No.	
Complaints referred for	
Date of Referral	

Medical History

Please give full medical history, including the following.

- Symptoms and diagnosis
- Dates of any diagnoses
- Clinical details indicating severity and permanence
- Relevant test results (e.g. lung function readings, X-ray or scan results)
- Treatment and response
- Other comments

_____

_____

Current major complaint(s) _____

_____

_____

Please comment on the member's ability to carry out the specified activities in the table below.

ACTIVITY	CURRENT LIMITATIONS				EXPECTED FUTURE ABILITY		
	No Limitation	Partial Limitation	Impossible	Danger to self and others	Improve	Remain constant	Deteriorate
Seated/sedentary tasks							
Clerical/administrative tasks							
Thinking clearly and making decisions							
Interacting with others							
Walking (non-strenuous) over level ground							
Walking (strenuous) over uneven ground							
Climbing							
Kneeling							
Standing							
Bending							
Operating light machinery							
Operating heavy machinery							
Driving a light motor vehicle							
Driving a heavy motor vehicle							
Light manual labour							
Use of both arms and legs							
Use of fine coordination							
Work in cramped conditions							
Work in dusty environment							
Work in fume environment							
Bathing							
Dressing							
Getting in and out of bed							
Maintaining personal hygiene							
Feeding onself							
Getting between rooms							

RESULTS OF MOST RECENT MEDICAL EXAMINATION

Date of Examination: D D M M Y Y Y Y

Please give full clinical details as at the examination, including height, weight, and blood pressure readings. Please include details of any limitations evident at the examination (e.g. joint limitations, visual acuities).

PROGNOSIS

What are chances of recovery Good/Fair/Poor/Nil)? _____

Are any residual problems likely? Please specify: _____

_____

Date expected to return to work: D D M M Y Y Y Y

DOES THE CLAIMANT USE TOBACCO IN ANY FORM? Yes ☐ No ☐ If "yes" please provide details:

_____

_____

_____

IS CURRENT MEDICAL IMPAIRMENT DUE TO:

a) Previous illness or injury Yes ☐ No ☐

b) The intentional consumption of alcohol, narcotics or any toxic substance Yes ☐ No ☐

c) Attempted suicide or any self-inflicted injury Yes ☐ No ☐

General comments, which may clarify the responses in the table. If improvement is expected, please indicate the time period in which that improvement is anticipated.

_____

_____

If period off work longer than usually expected for impairment, please give reason.

_____

_____

TREATMENT AND REHABILITATION

Current treatment regime. Please specify all medications and dosages:

_____

_____

Other treatment the claimant has received or is currently receiving (e.g. physiotherapy, occupational therapy, psychotherapy):

_____

_____

Planned future treatment, including surgery:

_____

_____

_____

_____

Your recommendations regarding rehabilitation (if applicable)

_____

_____

_____

_____

Name of Doctor: _____ Registration Number: _____

Postal Address: _____

_____

Landline No.: ☐☐☐☐☐☐☐☐☐☐ Mobile No.: ☐☐☐☐☐☐☐☐☐☐

Email address: _____ Qualification: _____

Declaration

I/We hereby certify that the above information is true and correct as per the records maintained by me/hospitals. I confirm that no information that could influence a decision regarding this claim has not been withheld. I hereby provide my consent to receive call from Aditya Birla Sun Life Insurance Company Limited (ABSLI) or its authorized Service Providers in connection with any matter related to this Policy.

Full Signature of Doctor: _____ Date of Report: ☐D ☐D ☐M ☐M ☐Y ☐Y ☐Y ☐Y

Any confidential information, which in your opinion should be in the possession of the Company, should be forwarded to Head Office at the below mentioned address.