Aditya Birla Sun Life Insurance Company Limited



FOR/11/17-18/1246

Critical Illness Claimant Form

To be completed by the Life Insured/Claimant

 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/ countersigned by the Life Insured. Claim processing will be initiated only post receipt of all mandatory documents along with completely Critical illness of Submission of this form will not be construed as acceptance of claim by the company. The Company reserves the rig additional document/ requirements. A. Documents to be submitted : Mandatory Requirements: Completely filled Critical illness claimant form, Family physician statement, Questionnaire form, Certificate by Employed in the statement. 	' ink must k claimant for
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 Medical Records (admission notes, discharge Summary, all Investigation reports supporting to diagnosis.) 	ei.
3) Cancelled cheque of policy owner/ copy of passbook detailing account information for Electronic payment.	
4) Original policy document or Indemnity Bond in case policy document is lost.	
5) KYC Document of life Insured.	
B. Additional Requirements in following scenarios:	
Heart Attack- All ECG & TMT reports, Cardiac Enzyme report	
Cancer- Histopathology report, PET CT scan	
Stroke - CT, MRI scans report, Certificate from Attending physician	
Cancer Shield Claim- Histopathology report, PET CT scan, Attending Physician Certificate- Cancer shield.	
CritiShield Claim - Medical records, CritiShield Cardiac / Renal benefit form as per ailment.	
1) Policy Number: EIA Number:	
2) Name of Insured:	
Address of Insured:	
Mobile No. (Mandatory):	
Email ID: M Y Y Y	
3) Nature of the Illness:	
4) Date of 1st diagnosis and investigations undergone: D D M M Y Y Y Y	
5) Have you previously suffered from or received treatment for a similar or related condition? If yes, give details inclu	uding durati
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Customer Acknowledgement Slip	<u> </u>
Customer Acknowledgement Slip	<u> </u>
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Customer Acknowledgement Slip Policy No.: Reference No.:	<
Customer Acknowledgement Slip	<u> </u>
Customer Acknowledgement Slip Policy No.:	≪

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6) Give particulars of Doctors consulted:

	Contact No.: _	
		Date/s of consultation
i) Family Physician		D D M M Y Y Y
ii) Specialist		D D M M Y Y Y
iii) Operating Surgeon		D D M M Y Y Y
Particulars of Hospital/Medical Centre where admitted	:	

I)	Name:	
ii)	Address:	
iii)	Telephone No.:	
iv)	Date of Admission: D D M M Y Y Y Y	Date of Operation: D D M M Y Y Y Y
	Date of Discharge: D D M M Y Y Y Y	
Please sub	omit the relevant reports	

Declaration

I hereby agree and confirm that the above details provided 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 Co. Ltd. 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 me /the deceased or my/ his health, to give to Aditya Birla Sun Life Insurance Company Limited, any and all information about me/ the deceased with reference to my/ his health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. I further authorize the Employers (past and present) of me/ the Life Insured to furnish to Aditya Birla Sun Life Insurance Company Limited, details of the leave availed of by me/ the Life Insured during the last three years of my/ his service together with copies of the leave applications and medical expenses. I also consent to a personal investigation. 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.

Date: D D M M Y Y Y Y	Place:
Name of Claimant/Policy Owner:	

Signature of First Claimant/Policy Owner: _____

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 M M Y Y Y Place:	
Declarant Name:	Declarant Signature
- X	×

Aditya Birla Sun Life Insurance Company Limited (Formerly known as Birla Sun Life Insurance Company Limited) Regn. No.: 109. Regd Office: One Indiabulls Centre, Tower 1, 16th Floor, Jupiter Mill Compound, 841, Senapati Bapat Marg, Elphinstone Road, Mumbai - 400013 +91 22 6723 9100 | claims.lifeinsurance@adityabirlacapital.com | www.adityabirlasunlifeinsurance.com | CIN: U99999MH2000PLC128110 Trade Logo "Aditya Birla Capital" displayed above is owned by ADITYA BIRLA MANAGEMENT CORPORATION PRIVATE LIMITED (Trademark Owner, and used by ADITYA BIRLA SUN LIFE INSURANCE COMPANY LIMITED (ABSLI) under the license

Contact Us: 1-800-270-7000



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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	()
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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, Aditya Birla Sun Life Insurance Company Limited (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 (ABSLI) 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's Signature

Declaration by Life Insured/Claimant:

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. 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.

Date: D D M M Y Y Y Place: _

Signature of Life Insured

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