

**PERMANENT PARTIAL AND TOTAL DISABILITY CLAIM  
(CLAIMANT'S STATEMENT)****DOCUMENT CHECKLIST**

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|--|--|
| <input type="checkbox"/> Claimant Statement form dully completed | <input type="checkbox"/> Original policy contract for permanent and total disability claim |
| <input type="checkbox"/> Medical Report duly completed           | <input type="checkbox"/> All the medical investigation report                              |
| <input type="checkbox"/> Hospital Records                        |  |

All payments shall be made according to terms and conditions of the policy.

The company retains right to call for further evidence needed to process the claim and to entertain or repudiate the claim.

Acceptance of forms does not amount to admission of claim

\*\*\*\* Please refer to the policy bond for the details.

Any one of the following must countersign this form. 1. An agent of Bajaj Allianz Life Insurance Co.Ltd. 2 Unit Manager of Bajaj Allianz Life Insurance Co LTD 3. An Advocate 4. A Bank Manager 5. A Block Development Officer 6. A Commissioner of Oaths 7. A Gazetted officer 8. President of Village Panchayat 9. A Magistrate 10. A Head postmaster 11. A Head master of a high school
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**PERMANENT PARTIAL AND TOTAL DISABILITY CLAIM  
(CLAIMANT'S STATEMENT)**

Agency/Location/Agent's Code: \_\_\_\_\_

1. This printed form is issued on receipt of notice of critical illness and/or permanent and total disability claim, and is no way an admission of liability
2. To be completed by the persons to whom the policy money is payable, if such person is unable to fill the form, it shall be filled by the authorized claimant.

**TO BE COMPLETED BY THE LIFE ASSURED / CLAIMANT**

Policy No	Claim No (For office use only)
Name of Life Assured	Age / Sex
Name of Claimant (if different from Life Assured)	
Relationship to Life Assured: Parents <input type="checkbox"/> Siblings <input type="checkbox"/> Friends <input type="checkbox"/> Spouse <input type="checkbox"/> Employers <input type="checkbox"/> Colleagues <input type="checkbox"/> Relatives <input type="checkbox"/> Others <input type="checkbox"/> (Pls specify _____)	
Address	Contact No (Res) (Off)

**EMPLOYMENT DETAILS**

Occupation	Date of Employment	DD	MM	YY
On what date did you last attend to your work		DD	MM	YY
Business name & address				
Contact No	Fax No			
Email Address if any:				

**SECTION I – TO BE COMPLETED FOR BOTH PARTIAL & TOTAL DISABILITY**

1. Please give full details of the extent & nature of your current illness				
2. Date of Diagnosis	DD	MM	YY	
3. On what date did symptoms first commence?	DD	MM	YY	
4. When did you first consult a doctor for this condition?				
5. Have you previously suffered for, or received treatment for a related or any major illness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If Yes, please give full details	
6. Please give details of the treatment, which you are currently receiving				
7. Have any of your blood/related relatives suffered from a similar or related illness? (If yes, please state the relationship of this relatives, nature of illness and date of illness)	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
8. Do you smoke cigarettes?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
(If yes, what is the daily consumption? And how long you have been smoking?)				
(If no, have you ever tried consuming? At what age? And how much per day?)				



Bajaj Allianz Life Insurance Company Ltd.

SECTION II – TO BE COMPLETED FOR PERMANENT AND TOTAL DISABILITY BENEFIT ONLY

9. Give exact details of your occupation (describe your daily duties)
10. Describe the functional capability, specifying continuous length of time of weight on a typical workday Sitting _____ Standing _____ Walking _____ Lifting _____ Carrying _____ Bending _____ Nightshift _____
11. If disability is the result of an accident, state where and how it occurred
12. What aspect of the disability prevents you from following your occupation?
13. Date Last worked                    DD    MM    YY                    Are you still totally or partially disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No
14. Have you been able to perform any work since the event of disability?
15. When do you expect to return to work?
16. Do you intend to seek alternative employment?
17. Is there any aspect of the disability that you think will prevent you working in any occupation? If so, please give full details.

DECLARATION AND AUTHORISATION BY LIFE ASSURED / CLAIMANT

I, \_\_\_\_\_, hereby declare that the information given in this claim form are true and that 1/the Life Assured did not suffer from any pre-existing condition, except as may be disclosed during the application at the time this policy was taken up. I / Life Assured further declare that the current confinement to the hospital is not due to any causes which are stipulated in the exclusion clause of the policy. I further agree that in the event that I make or having in the past made any false or untrue statement and/ or suppressed and/ or concealed any material fact in respect of my / the Life assured's health condition, the company shall absolutely forfeit my / Life Assured's right to compensation and reserve the right to recover any amounts paid earlier as a result thereof.

I, \_\_\_\_\_, having read and understood the contents hereby authorize any physician, hospital, clinic or insurance company or other organization, institutions, or persons that has any records or knowledge of me/Life Assured or my/Life Assured's health to disclose to BAJAJ ALLIANZ LIFE INSURANCE COMPANY LIMITED or its representative any and all such information and expressly waive on behalf of myself / the Life Assured or any person who shall have any claim or interest in any policy issued hereunder, all or any provision of law prohibiting any physician or surgeon from disclosing any information acquired while attending to me / the Life Assured in a professional capacity. This authorization shall irrevocably bind my successors and assigns and remain valid, notwithstanding my / the Life Assured's death or incapacity and a copy of this shall be as effective and valid as the original

_____ Signature of Life Assured Date Address	_____ Signature of Claimant Date Address
_____ Signature of Witness Name Date Address	_____ Signature of Witness Name Date Address