BAJAJ Allianz

LIFE GOALS. DONE.

# Application Form For Disability Benefit Claim – Claimants Statement

(Personal Accident Benefit / Waiver of Premium / Payor Rider Disability)

(A qualified and registered medical practitioner should complete this form. Policy Holder, Life Insured who are also medical practitioners or their Spouse, or Lineal Relative of Policy Holder/Life assured cannot fill it).

Notes/Guidelines

- This form is to be filled in by the person legally entitled for the policy money. All the answers must be clear & unambiguous.
- The benefit is payable subject to policy being in force on the date of event and also subject to fulfillment of all conditions/definitions as stated in the policy.
- Submission of this form should not be construed as acceptance of claim.
- Speedy and complete submission of documents would enable the company to expedite the claim processing.

Policy No: ☐☐☐☐☐☐☐☐☐☐ Contact No of Life Assured: ☐☐☐☐☐☐☐☐☐☐

## I. Information about the Life Assured

1 a) Name of the Life Assured _____

b) Complete Mailing Address _____

_____ c) Age at Claim D D M M Y Y Y Y

## 2.Bank Details (Mandatory)

Name as per Bank Records: _____

Bank Name and Branch: _____

Bank Account No. : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

MICR Code: ☐☐☐☐☐☐☐☐☐☐☐ IFSC Code: ☐☐☐☐☐☐☐☐☐☐☐

(It is advisable to submit cancelled cheque for cross verification of bank details)

## II. Information about the Disability

1. Date of Accident/Diagnosis/Disability, as the case may be _____
2. Details of Diagnosis _____

_____

3. Nature of Disability-(Tick any one) Permanent ☐ Temporary ☐
4. Extent of Disability-(Tick any one) Total ☐ Partial ☐
5. Is the Patient capable of performing the following activities of daily living

Dressing ☐ Using the Toilet ☐ Walking ☐ Feeding Him/Herself ☐ Using Telephone ☐ Bathing ☐ Taking Medication ☐

6. Is the Life Assured capable of engaging in any gainful activity or carrying out any work, occupation, or profession to earn or obtain any wages, compensation, remuneration or profit _____

## III. Information about the Doctors consulted and Hospitals where treatment was taken:

| S.No. | Name of Doctor/ Hospital | Contact Number | Date of First Consultation | Treatment Taken |
|---|---|---|---|---|
| | | | | |
| | | | | |

b) Name of Family Doctor _____ Contact No of Life Assured: ☐☐☐☐☐☐☐☐☐☐

## IV. Information about the Accident (if applicable)

1. Date of Accident _____

2. Place of Accident _____

3. Name of Police Station (where Accident was reported) _____

4. First Information Report (FIR) Number _____ Date of FIR _____

## V. Declaration And Authorization

I _____ do hereby declare that the statements made herein above are true and complete in all respects. Notwithstanding any law, custom or convention, or usage, for the time being in force prohibiting any physician or hospital from divulging any knowledge or information, acquired by him / them in attending upon of examining a person on the ground of secrecy. I hereby authorize any doctor, physician or hospital who has attended upon or examined or treated me for any ailment or illness to divulge any knowledge or information regarding my state of health which he / they may have acquired whether before or after the policy was issued by the Company, to the Bajaj Allianz Life Insurance Company.

Signed at _____ (Place) on this _____ Day of. _____ Month _____ Year.

Signature of Life Assured

**Signature of Witness- Mandatory**

Name: _____

Address: _____

Phone No. (With Std Code) | | | | | | | | | | |

Signature

The form must be witnessed by any one of the following: (1) An Agent (2) Sales Manager / Branch Manager of the company (3) Block Development officer (4) A Bank Manager of a Nationalized bank with Rubber Stamp (5) An officer of the Company not below the rank of Manager (6) A Gazetted Officer (7) A Head Master / Principal of a Govt. School (8) A Magistrate.

(Full Signature of the Witness)

1. Name of Agent Advisor / CRO: _____ Agent / CRO Code: _____

2. Name of Sales Manager _____ SM Code: _____

## VI. Documents to be submitted along with this form

1. Attending Physician's Statement.
2. Medical Records with dates- Admission notes, Discharge Summary/Card, Procedure /Surgery notes, all medical test reports, prescriptions, consultation notes, previous medical records and other insurance documents etc.
3. FIR/Police Report/Panchnama/Inquest Report (only in case of accident).
4. Copy of driving license (only in case of Road Traffic Accident).

**NOTICE:** Any person who knowingly files a claim containing false or misleading information, or who conceals information with intent to defraud or mislead the Company or other person, may be guilty of felony or subject to other criminal and/or civil penalties as the case may be under the applicable law(s) of the State.

## Electronic Funds Transfer- Mandate form

I Mr./Ms._____,son/daughter/wife of _____resident of_____ _____ am a claimant/Policy Holder under the Policy Number_____. I do hereby request Bajaj Allianz Life Insurance Company Limited electronically transfer the claim payment under the above mentioned policy number in to my bank account as per detail given below.

## 2.Bank Details (Mandatory)

Account Holder Name:_____

Bank Name: _____

Type of Bank Account:_____ Bank Account No. : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Branch Address: _____

MICR Code: ☐☐☐☐☐☐☐☐☐☐☐ IFSC Code: ☐☐☐☐☐☐☐☐☐☐☐

(It is advisable to submit cancelled cheque for cross verification of bank details)

## Declaration

I agree to save and hold Bajaj Allianz Life Insurance Company Limited harmless and indemnified against any and/or all losses, claims, liabilities, legal proceedings (including attorney fees'), expenses, or damages suffered by or taken against Bajaj Allianz Insurance Company Limited arising on account of any error or misrepresentation in the information furnished in this NEFT mandate by me.

Date: D D M M Y Y Y Y

Account Holder / Claimant Signatures:

Bank Verification - _____

I, the undersigned authorized person, on behalf of the above mentioned bank, confirm that the bank account details of the individual as mentioned in this NEFT Mandate form are correct and are hereby verified

Name of Bank_____ Bank verification Stamp with branch address and Signature of the Banker_____ Name of the Signing authority_____

**Please attach a copy of cancelled Cheque / copy of bank account passbook bearing the above mentioned account number along with this form.**