



i) Please state the Name, address and Telephone numbers of the Doctor(s)/ Medical Centers consulted during the illness:

Name of Hospital/ Doctor	Address & Tel. No.	Regn./ License No	Date of Admission	Date of Operation (if any)	Date of Discharge

3) Name & addresses of the Doctors who treated you during the last three years & the illnesses for which the treatment was availed.

Name of the Doctor	Address	Contact No. (From – To)	Period of Consultation	Disease/ disorder

4) Details of Critical Insurance coverage /Mediclaim coverage of the Life Assured:

Policy No	Insurer	Nature of coverage (i.e. Mediclaim or CI)	Effective Date.	Effective Date.

DECLARATION AND AUTHORISATION: I/We, the above-named claimant(s), do declare that the foregoing answers and statements are true in all respects, and further agree that the furnishing of this form, or any other form supplemental thereto, to the Bandhan Life Insurance Ltd (the "Company") and acceptance of the same by the Company shall not constitute an admission by the Company that there was any insurance in force on the life in question or a waiver of any rights or defence. Notwithstanding, any law, custom or usage, prohibiting the furnishing of secret information obtained during the medical treatment / investigation of Life Insured, I/We hereby authorize any doctor or other person, or any hospital, sanatorium, medical professional, hospital or other medical care institution, insurance support organization, pharmacy, governmental agency, insurance company, employer, benefit plan administrator accountant, or financial adviser or other entity to provide to Bandhan LIFE INSURANCE LTD., any of its offices, or Court of Law, or any investigative agency of the said Company acting on its behalf, information concerning employment, finances or insurance, advice, care or treatment provided to deceased, or any information that may be required concerning the health of the deceased (Life Insured) including information relating to mental illness, use of drugs, use of alcohol, HIV(AIDSVirus) and /or sexually transmitted diseases. A Photostat copy of this authorization shall be considered as effective and valid as the original.

Signature of the Claimant

Address

Signed at \_\_\_\_\_ (Place) on this \_\_\_\_\_ Day of \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

Signature of Witness

Name :

Phone:

Address :

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

Declaration in case of an illiterate Claimant where authentication of his/her left thumb impression should be made by a person of standing unconnected with the Company and whose identity can be easily established.

"I hereby certify that the contents of above form have been explained by me to the Claimant in the language understood by the Claimant and that he/she has affixed his/her thumb impression to this form in my presence after fully understanding the contents thereof ."

Name:

Signature:

Address:

**Registered Office:**

Bandhan Life Insurance Limited.  
A-201, 2nd Floor, Leela Business Park, Andheri-Kurla  
Road, Andheri (E), Mumbai - 400059.

Formerly Aegon Life Insurance Company Limited

Corporate Identity No:  
U66010MH2007PLC169110.  
IRDAI Company Registration  
Number: 138

☎ 1800 209 90 90  
(Toll free, 9 am to 7 pm, Mon to Sat)  
✉ customer.care@bandhanlife.com  
🌐 www.bandhanlife.com