



Important instructions for completing the form

- ▶ To be filled in by the person legally entitled for the policy money. All the details called for must be furnished and all answers must be clear & unambiguous
- ▶ All fields under "Information about the Life Assured" and "Bank Account Details" section are mandatory.

Policy No

Information about the Life Assured

Name

Age In Years

Address

Occupation

Office Address

Residence Telephone No. (with STD code)

Mobile No.

Bank Account Details

Mandatory - The Claimant should be a holder of the Account

Bank Name

Bank Account No.

Information about the Terminal Illness for which the claim is being made

Please state the specific terminal illness for which the claim is being made

Immediate Cause of Admission into a hospital/ Nature of complaint

Diagnosis arrived at

Date of Diagnosis of terminal illness

Name and Address of the Hospital(s)



When did the Life Assured first complain of the illness or experience symptoms of the same?

Duration of Illness

Treatment given

Date of commencement of treatment

Investigations done and tests conducted

NOTE

Please submit all investigation reports (E.g.: Blood reports, ECG, Angiography, Histopathology etc.) along with the Discharge summary from Hospital with the report of operating surgeon and any other related report(s)

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.	
Registration/ License No	Date of Admission
Date of Operation (if any)	Date of Discharge

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

Details of Critical Insurance coverage/Medicaid coverage of the Life Assured

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



Declaration & Authorization

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(AIDS Virus) 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 of the Claimant

Grid of 40 small boxes for address entry.

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

Signature of Witness

Contact no. of witness

Grid of 15 small boxes for contact number entry.

Name of witness

Grid of 40 small boxes for name entry.

Address of witness

Grid of 40 small boxes for address entry.

The form must be witnessed by any one of the following

- Block Development Officer
- A Bank Manager of a Nationalized Bank with Rubber Stamp
- An Officer of the Company not below the rank of Manager
- A Gazetted Officer
- Head Master / Principal of a Govt. School
- A Magistrate
- Notary Public



Vernacular Declaration

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 of the Witness

Grid for Name of the Witness

Address of the Witness

Grid for Address of the Witness

Contact No. of the Witness

Grid for Contact No. of the Witness

Signature of the Witness

