ANNEXURE - B

LIFE INSURANCE CORPORATION OF INDIA

Divisional Office . Branch Office .

Claim for Disability/Sickness Benefit under Nav Prabhat Plan
(Questionnaire to be completed by the Life Assured claiming Disability/Sickness Benefit)

Policy No.: _____ Claim No.: _____

Name of the Life Assured: _____ Present Age: _____

Address : _____

_____

Tel.No:_____ Mobile No.: _____

Fax No.: _____ E -ma il : _____

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I. Particulars of all insurance policies held by the LA including mediclaim policies :

Name of the company Policy no. DOC Sum Assured Present Status

(a)

(b)

(c)

(d)

II. 1. Nature of disability

2. Parts of the body affected:

3. Since when you are disabled (date) :

4. Describe in brief the incident as a result of which you were incapacitated :
Mention the date, time & place of the incident :

5. If the disability is the result of an accident, whether the accident was reported to the Police Station ?:

(a) If Yes :
(i) Name of the reported Police Station :
(ii) Police case no. (with date) :
(Attach a copy of the FIR, Panchnama, Final Police Investigation Report certified by the Police Authorities and newspaper cuttings, if any)

(b) If No :
(i) State the reasons :
(ii) Details of two witnesses to the incident :
(Mention full names, addresses and relationship with you) :

6. (a) Mention the nature of injuries received and the parts of the body affected:
(b) Details of the Hospital/s Doctor/s which/who treated you for the ailments/ injuries/disablement:

Note : Please attach certificate issued by the doctor/s and hospital/s and copies of all reports including hospital discharge summary, medical investigation reports, consultations, followup reports, prescriptions in regard to the treatment for ailments/injuries/disablement.

7. Give details of current treatment, if any :
8. Please state your present vocation:

I, . hereby declare that the foregoing statements are true and correct to the best of my knowledge.

I authorise the Hospital/s and Doctor/s who have examined or treated me for any ailment or illness and my employer or its officers or any other person to provide information regarding the illness which they may have acquired before or after the policy was issued by the LIFE INSURANCE CORPORATION OF INDIA to the company or its officers.

I agree to provide necessary information and reports to LIFE INSURANCE CORPORATION of India for processing this claim.

Dated at ..... . this ..... day of .... 20 .....

Signature /Thumb Impression of the Life Assured :

Name of Life Assured:

Signature of Witness:

Name:

Designation:

Address:

If the signature of the claimant is in vernacular or thumb impression, the witness should also sign the following:

I certify that I have explained the contents of this form to the claimant in _____ language and he has affixed his/her signature/thumb impression after fully understanding the same.

_____
Signature of the witness

DECLARATION

Note : This should only be completed if the Life Assured with disability is unable to complete the form himself due to complete inability to sign or put his thumb impression.

On behalf of the _____ (the Life Assured), I _____ (name and relation to the Life Assured) do hereby declare that the statements made hereinabove are true and complete in each and every respect.

On behalf of the Life Assured, I authorise the Hospital and Doctors who have examined or treated the Life Assured for any ailment or illness or any other person to provide information regarding the illness which may have acquired before or after the policy was issued by

LIFE INSURANCE CORPORATION
OF INDIA.

I also agree to provide and furnish details and reports as and when required by LIFE INSURANCE CORPORATION OF INDIA for processing the claim.

Date : Signature of the declarant

Place : Name of the declarant

Address of the declarant

Telephone number