LIFE INSURANCE CORPORATION OF INDIA

Claim Form : AD (KF)-1

Divisional Office: Branch Office:

Re: Kidney Failure Claim under Asha Deep Policy No. _______________

favouring ____

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(Note: This form should be completed by the Life Assured)

1) Full Name :

Address :

2) Whether you had any complaint, of Date: / /
hypertension, diabetes and/or kidney Complaint :_______________
disease? If so, give details: Investigations

Undergone :_______________
Treatment :_______________
____
____

3) Give below the date/s on which you first
consulted the doctors for kidney ailment: Name & Address Date/s of Consultation

i) Medical Attendant:

ii) Nephrologist:

iii) Operating Surgeon:

4) State since when you are on Dialysis : Date: / /

5) Give No.of times you require renal dialysis : I / Time/s per week.

During the last month : I / Time/s per week.

During the previous to last month : I / Time/s per week.

During the preceding month to previous month : I / Time/s per week.

6) Name & Address of Hospital or Medical Centre: For Dialysis ForTransplantation

Tel. No.
Date of first admission : ////
Date of first renal dialysis : ////
Date of last renal dialysis : ////
Date of Kidney transplantation : ////
Date of last discharge : ////
Please submit in original all the reports, follow up reports including all investigation reports, dialysis card**& LAST DIALYSIS CERTIFICATE.**

(In case any of the reports are not submitted, give reason for the same.)

7) Do you have any other Asha Deep Policy? If so, give details:

Policy No.	Date of Commencement	Sum Assured	Servicing LIC Branch Office

I, .do hereby declare that the statements made herein above are true and complete in each and every respect. Notwithstanding the provisions of any law, usage, custom or convention for the time being in force prohibiting any physician or Hospital from divulging any knowledge or information acquired by him/them in attending upon or examining a person on the ground of secrecy, I hereby authorize the Physician or Hospital who has attended 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 Corporation, to the Corporation, its offices and legal advisers or in any court of law.

Name & Signature of witness Signature / thumb impression of the Life Assured
Designation :
Address:

If the claimant signs in vernacular or affixes thumb impression, the witness should also sign the following declaration:

Certified that the contents of this form were explained to the declarant in vernacular and he/she has affixed his/her signature/thumb impression hereto after fully understanding the same.

Signature of witness.