ANNEXURE III

LIFE INSURANCE CORPORATION OF INDIA

Claim Form JB(CDB)-1

Branch Office :

Divisional Office :

Re: Congenital Disability Benefit claim under Jeevan Bharati

Policy No._____Fvg._____

(This form should be completed by the Life Assured in case of Congenital Disability Benefit)

1) Full Name :

Address :

2) Date of birth of the child :

3) Whether the child is suffering from any
congenital disability :
If yes, give details :
a) Nature of the disability
b) Date of diagnosis
c) Treatment taken

4) Whether the child was born as a result
of fertility treatment or in-vitro fertilization?

5) Give below the dates on which you first consulted the following Doctors for
congenital disability of the child :

Name & Address **Date (s)**

i) Medical Attendant

ii) Pediatrician/Specialist

6) State the name and address of the Name :
Hospital or Medical Centre where
your child was/is undergoing Address :
treatment for the disability Tel.No.

Date of first admission :

Details of treatment :

Details of subsequent treatment (if any)

7) Whether the benefit has been claimed earlier? Yes / No
If yes, furnish the details.

Please submit in original :

i) Hospital Discharge Card

ii) Blood reports, x-ray plate(s) and report (s)
and any other investigation report (s) done

8) What is the present condition of the child?

9) Do you have any other Jeevan Bharati Policy? If so, give details :

Policy No. Date of commencement Sum Assured Servicing Branch Office

I, _____ do hereby declare that the statements made hereinabove 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 grounds of secrecy, I hereby authorize the Physician or Hospital who 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 Corporation, to the Corporation, its offices and legal advisers or in any court of law.

Name & Signature of Signature/thumb impression
Witness of the Life Assured
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 above Life Assured in vernacular and she has affixed her signature/thumb impression hereto after fully understanding the same.

Signature of Witness