# APPLICATION FORM FOR ACCIDENTAL DISABILITY CLAIM CLAIMANTS STATEMENT

**(To be filled in by the person legally entitled to the policy money. All the details sought for must be furnished and must be clear & unambiguous)**

Policy Number (s) :

Date : D D M M Y Y Y Y

**I. Information about the Claimant (if different from Life Assured)**

1 a) Name of the Claimant : 1)

2)

b) Complete Address & Tel. No. :

c) Age of Claimant (In Years) :

d) Relationship of the Claimant to the Deceased : ☐ Parent ☐ Spouse ☐ Son/ Daughter

☐ Others (Specify)_____

e) Bank Details (Mandatory - (The Claimant should be a holder of the Account))

Bank Name :

Bank Account No. :

Contact No. of the Bank :

Address of the Bank :

**II. Information about the Life Assured and Accident**

2 a) Name :

Age (at the time of disability) :

b) Date of Accident : D D M M Y Y Y Y

c) Place of Accident :

d) Time of Accident :

3 a) Last Employer's name and address :

b) Designation : _____

4 Last residential address :

a) How did the accident occur? : _____

b) People involved in the accident : _____

c) Details of disability/ Dismemberment : _____

| Physical impairment area (Limbs, Eyes etc) | Nature of impairment (Permanent/ Temporary) | Time elapsed from this impairment (# of days) | Is the LA still under hospitalization? |
|---|---|---|---|
| | | | |
| | | | |

d) Name and address of Police Station where FIR was lodged (Please furnish a copy of the FIR) :

e) FIR No. : f) Tel.:

5) Name and address of Hospital (where last /current treatment was/ is conducted) :

6) Did the Life Assured suffer from any ongoing or recurrent health problems? If yes, please furnish the details below. : ☐ Yes ☐ No

I) Nature of illness/ ailment/ disorder :

II) Duration of illness/ ailment/ disorder :

III) Name of the doctor/ hospital where the Life Assured was treated for the same :

7) Name & Addresses of the Doctor/ Hospital(s) who treated him / her during the last three years & the ailments treated by them:

| Name of the Doctor/Hospital | Address | Contact No | Date of Consultation/ Admission | Disease/Condition |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

8) Particulars of other Life Insurance/ Mediclaim policies held by the Life Assured

| Policy Details | Policy 1 | Policy 2 | Policy 3 | Policy 4 |
|---|---|---|---|---|
| Policy Number | | | | |
| Name of the Company | | | | |
| Commencement Date | | | | |
| Base Sum Assured | | | | |
| Rider Sum Assured | | | | |
| Year of Claim | | | | |
| Cause of Claim | | | | |
| Amount Claimed | | | | |

9) Any other information, which you consider, would be vital in the claim review process under this policy? : _____

**III. Declaration And 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 Aegon Life Insurance Company 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 Aegon Life Insurance Company 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 Claimant (No.1) _____ (No.2) _____

Signed at _____ (Place) Date _____

**Signature of Witness - Mandatory**

Name : _____

Address : _____ _____

_____ Phone _____ Signature:

The form must be witnessed by any one of the following: (1) An Agent (2) Sales Manager / Branch Manager of the company (3) Block Development officer, (4) A Bank Manager of a Nationalized bank with Rubber Stamp, (5) An officer of the Company not below the rank of Manager, (6) A Gazetted Officer, (7) A Head Master / Principal of a Govt. School, (8) A Magistrate

**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 :

Address :

(Full Signature of the Witness)

**Document Checklist**

1. Claimants Statement
2. Medical Attendant Certificate
3. Proof of Age
4. Post Mortem report – Duly Certified (Accidental death)
5. Police report for accident claims
6. Consent letter duly signed
7. Original Policy document
8. Original Death Certificate

✓ **All payments shall be made according to terms and conditions of the policy. The Company retains the right to call for further evidence needed to process the claim and to entertain or repudiate the claim.**

✓ **Acceptance of forms does not amount to admission of the liability by the Company**