

Application For Terminal Illness Claim

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.

Policy No.(s)	:	
I. Information about the Life Assured :		
a) Name of the Life Assured	:	
b) Age	:	
c) Address	:	
d) 1) Occupation	:	
2) Office Address	:	
e) Telephone number- Residence (with STD code)	:	
		Mobile No. style="border-bottom: 1px solid black;">
f) 1) Name of the Bank (Mandatory)	:	
2) Bank Account No.	:	
2. Information about the Terminal Illness for which the claim is being made :		
a) Please state the specific Terminal Illness for which the claim is being made	:	
b) Immediate Cause of Admission into a Hospital/ Nature of complaint	:	
c) Diagnosis arrived at	:	
d) Date of Diagnosis of Terminal Illness	:	D D M M Y Y Y Y
e) Name and Address of the Hospital(s)	:	
f) When did the Life Assured first complain of the Illness or experience symptoms of the same?	:	
g) Duration of Illness.	:	
h) (1) Treatment given	:	
(2) Date of commencement of treatment	:	D D M M Y Y Y Y
(3) Investigations done and tests conducted	:	
NOTE: Please submit all investigation (E.g.: Blood Reports, ECG, Angiography, Histopathology, Radiology Reports like CT scan, MRI etc.) along with the discharge summary from Hospital with the report of operating surgeon and any other related report(s)		

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

3) 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.	Period of Consultation (From – To)	Disease/ disorder

4) Details of Terminal Insurance coverage/ Mediclaim coverage of the Life Assured:

Policy No.	Insurer	Nature of coverage (i.e. Mediclaim or TI)	Effective Date	Terminal Illness Cover (₹)

DECLARATION AND AUTHORISATION: 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 AegonLife 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 authorise any doctor or other person, or any hospital, sanatorium, medical professional, hospital or other medical care institution, insurance support organisation, 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 authorisation shall be considered as effective and valid as the original.

Signature of the Claimant _____

Address _____

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

Signature of Witness - Mandatory

Name : _____ Signature: _____

Address : _____

_____ Phone _____

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(9) Notary Public

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)