AEGON Life
An Aegon and Times Group Company

Claim form-Covid 19 rider

In order to help us process your claim faster, please read the instructions given below

1. Form to be filled by claimant in BLOCK letters
2. Only the person entitled to receive the policy monies under the policy shall fill & sign the form
3. Rider benefit is payable subject to policy being Inforce on the date of Hospitalization and other policy conditions
4. Regulatory guidelines require insurers to pay all payouts due to policyholders/nominee/assignee by directly crediting the money into their bank account. Copy of self-attested cancelled cheque bearing pre-printed name of beneficiary/ bank passbook of beneficiary is mandatory to enable NEFT payment

Document checklist:

1) Claim form duly filled & signed ☐
2) Copy of Hospital discharge summary ☐
3) Copy of Covid-19 test report & other lab reports ☐
4) KYC documents of claimant ☐
   - **a)** PAN or Form No 60 ☐
   - **b)** Copy of any one of the following (Identity & address proof of claimant)
     - **I.** Passport (unexpired) ☐
     - **II.** Driving License (Unexpired) ☐
     - **III.** Voter's Identity Card ☐
     - **IV.** Job Card issued by NREGA duly signed by an officer of State Government ☐
     - **V.** Proof of possession of Aadhar number(first 8 digits to be masked) in such a form as issued by the Unique Identification authority of India (means 'Aadhar Card') ☐
5) Copy of self-attested cancelled cheque bearing pre-printed name of beneficiary/Passbook copy of the claimant ☐

Details of the Insured

Master policy no. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	Certificate of insurance no. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Insured name: ____________	Mobile no: ☐☐☐☐☐☐☐☐☐☐
Date of birth: D D M M Y Y Y Y	E-Mail ID: ____________
Gender: Male ☐ Female ☐	Bank Name & Branch: ____________
Complete address: ____________	Bank a/c no: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
____________	Account type: ____________
City: ____________ State ____________	IFSC Code : ☐☐☐☐☐☐☐☐☐☐☐
Pin code: ☐☐☐☐☐☐	MICR code: ☐☐☐☐☐☐

Details of Hospitalization

Date of diagnosis of Covid-19: D D M M Y Y Y Y Name of hospital : ____________	Complete address of the hospital: ____________
Date of admission : D D M M Y Y Y Y	Time: HH:MM : ☐☐☐☐
Date of discharge : D D M M Y Y Y Y	Time: HH:MM : ☐☐☐☐

Declaration & Authorisation

I/We, the claimant(s), do declare that the foregoing answers and statements are true in all respects, and further agree that the furnishing of this form, orany 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 defense. I/We, the claimant(s) of this policy hereby give my/our consent to Aegon Life Insurance Co. Ltd. And/or its representative to obtain all past & present employment/ birth register/ life & non-life insurance company/medical/Govt. or Pvt. Hospital records/Other records (including photocopies)/information pertaining to the treatment/occupation of the Life assured and/ or conduct such investigations as it may deem fit. We agree that payment of claim amount shall constitute discharge of liability of Aegon Life Insurance Co.Ltd

Signature/ Left thumb impression of claimant

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Signature of witness: ______________________

Name & address of witness ______________________

Vernacular Declaration (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 claimant in vernacular and he/she has affixed his/her signature/thumb impression hereto after fully understanding the same.

Name & address of witness: ____

Contact no. of witness: ______________________ Signature of witness: ______________________

Witness declaration to be signed by any of these: person of local standing / Special Executive Magistrate / Notary / Lawyer / Class 1 Gazetted Officer

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IRDAI Company Registration Number: 138

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