CLAIMANT STATEMENT FORM (RIDER CLAIM):

FORM (A-2)

edelweiss life insurance

Without prejudice

- The form needs to be completed by the Life Assured/Beneficiary under the policy
- Please ensure all questions are answered. Ensure use of "Not Applicable" (N/A) instead of leaving it blank
- Claim proceeds are payable as per terms & conditions mentioned in the policy document and subject to the policy being inforce as on the date of event
- Early & Complete submission of requirements would enable the company to process claims at the earliest
- The company reserves the right to call for additional documents / requirements
- Kindly submit the copy of the Discharge Summary / Indoor medical records along with this form

Submission of ID proof of the claimant is mandatory along with this form

Policy No.: | | | | | | | | | | | | | | | |

Particulars	Details of the Life Assured
Name	Mr./Mrs./Master/Ms. _____
Address	_____
	_____ Pin Code: _____
	Tel. No.: _____

Details of the Claim	
Rider under which the claim is being made	☐ CI Rider ☐ ATPD ☐ HCB ☐ WOP ☐ PWB
Illness diagnosed	_____
In case of claim under CI or HCB please provide the following:	
Date of diagnosis	D D M M Y Y Y Y
Name & address of the doctor who diagnosed the illness	_____ _____ Tel. No.: _____
Name of the hospital where the Insured was admitted	_____
Date of admission:	D D M M Y Y Y Y (Indoor patient no: _____)
Date of discharge	D D M M Y Y Y Y
Symptoms related to current illness	_____ _____
Duration of the said symptoms	_____
Progress	☐ Improved ☐ Recovered ☐ Unimproved
In case of claim under ATPD please provide the following:	
Nature of disability	☐ Permanent ☐ Temporary
Name of the hospital where the insured was admitted	_____
Date of admission:	D D M M Y Y Y Y (Indoor patient No.: _____)
Date of discharge	D D M M Y Y Y Y
Date of disability	D D M M Y Y Y Y
Date of accident	D D M M Y Y Y Y
Place of accident	_____
Name of the police station where the FIR has been lodged	_____
	_____

Date of FIR	D D M M Y Y Y Y (Please attach the copy of FIR along with this form)
Progress	☐ Improved ☐ Fully recovered ☐ Unimproved
Is the Life Assured capable of performing any occupation or engaging in activities for remuneration or profits?	☐ Yes ☐ No

PREVIOUS HEALTH/ HABIT DETAILS OF LIFE ASSURED:

Nature of Illness / Habit	Please Select Yes/No		Duration (since when)	If Yes, Quantity Details
Hypertension	Y	N		
Diabetes	Y	N		
Heart disease	Y	N		
Kidney disease	Y	N		
Liver disease	Y	N		
Cancer	Y	N		
Any other ailments / disorder/ surgery/ hospitalisation in last 5 yrs	Y	N		
Any habits like smoking/ alcohol/ tobacco/ drugs (Please select)	Y	N		

Payment Details

Details of hospitalisation expenses and mode of payment				
Details of amount claimed under Mediclaim/health insurance policy during last five years	Name of the Insurer	Sum Assured	Amount of claim received	Date of claim

Other details of the Life Assured:

Employment details	
Last Employer's / Business name:	_____
Address	_____ _____
Designation at work place/business:	_____
Last working date:	D D M M Y Y Y Y
Annual income	_____
Nature of Job/ Business	_____
Family Physician details	
Name of the doctor	_____
Address & Tel. No.	_____ _____
Since when has been the Life Assured taking treatment from the doctor	_____
Name the illness for which treatment was taken	_____

Particulars of other Life Insurance / Mediclaim policies held by the Life Assured						
Name of the Co./ TPA	**Policy No.**	**Risk Commencement Date**	**Sum Assured**	**Claim Raised Yes/No**	**Status of Claim**	**Amount Claimed**

Electronic Payout option (Direct transfer of funds in your bank a/c)

1. Name of the Bank A/c holder: _____
2. Bank Name: _____ Branch Name: _____
3. A/c No.: _____
4. A/c Type: ☐ Saving ☐ Current ☐ NRI ☐ NRO
5. IFSC code: _____ MICR Code: _____

☐ Personalised cancelled cheque required along with this form

Payouts would be in accordance and subject to the terms and conditions of the policy. Further, the company reserves the right to use any alternative payout option including demand draft/payable at par cheque in spite of opting for Electronic payout method. I will not hold Edelweiss Life Insurance Company Ltd. responsible in case of non-credit to my bank account or if the transaction is delayed or not effected at all for reasons of incomplete/ incorrect information.

Date: D D M M Y Y Y Y **Signature / Thumb impression of the claimant:** _____

I, Mr. / Ms. / Mrs. _____ (name), _____ (relation) of

Mr. / Ms. / Mrs. _____ (name of the Life Assured), do hereby declare and confirm that I am the rightful claimant of the deceased person and the above statements are true and complete in each & every respect.

In order to enable the company to assess the claim under this policy, I authorize the Company to procure documents/details from the

- past and present employer (s) business associates
- Medical practitioner/ Hospitals (Govt/ Pvt.)
- Any life and non life insurance company

And hereby give my consent to the above authorities to release to the company, such details/documents which may be required during the assessment of the claim.

In case where the Policy document is not submitted to the Company I, hereby agree to indemnify the Company against all liabilities that the Company may incur on account of any claim being made by any other person on the basis of possession of the Policy document or otherwise.

Yours Faithfully,

Signature / Thumb impression of the claimant	**Name & signature of the witness** Name: _____ Signature: _____ Relation with the claimant: _____
Telephone with STD code: _____	Telephone with STD code: _____
Place: _____	Place: _____
Date: _____	Date: _____