

CLAIM INTIMATION CUM CLAIMANT'S STATEMENT (DISABILITY CLAIM)

(Format : AQ)

Guidelines / Notes:

1. The benefit is payable subject to the policy being in force on the date of event and also subject to the fulfillment of all conditions / definitions as stated in the policy.
2. Only the person entitled to receive the policy monies under the Policy should fill & sign this form.
3. Submission of this form should not be construed as acceptance of claim.
4. Please submit the form & the requirements at the nearest branch office or the address given below;
ICICI Prudential Life Insurance Company, Claims Department,
4th Floor, Stanrose House, Appasaheb Marathe Marg, Prabhadevi, Mumbai- 400 025.
5. Early and complete submission of requirements would enable the company to process the claim at the earliest.

Policy Number(s): _____

1. Details of the Life Assured:

Full Name:	Age at Claim:
Current Residential Address:	Tel. No.:
City / Town:	Pin Code: State:

2. Details of the Claimant if different from Life Assured (person entitled to receive claim proceeds under the policy):

Full Name:	Date of Birth / Age:
Current Address:	Tel. No.:
City / Town:	Pin Code: State:
Residential Status:	<input type="checkbox"/> Resident Indian <input type="checkbox"/> Non Resident Indian (NRI) <input type="checkbox"/> Other
If NRI, please state Country of Residence:	
Relationship with the Life Assured:	<input type="checkbox"/> Self <input type="checkbox"/> Other _____
Nature of title to the Policy monies:	<input type="checkbox"/> Proposer <input type="checkbox"/> Assignee

Requirements to be submitted alongwith this form.

(Please Tick)

1. Original Policy Document	<input type="checkbox"/>
2. FIR / Panchnama / Inquest Report	<input type="checkbox"/>
3. Medical Records (admission notes, discharge summary, test reports etc)	<input type="checkbox"/>
4. Copy of Driving License if Life Assured was driving the vehicle at the time of accident	<input type="checkbox"/>
* The following certificates are available at the branch office and should be collected from there:	
5. Treating Doctor Certificate	<input type="checkbox"/>
6. Employer Certificate (in case salaried)	<input type="checkbox"/>
<i>The Company reserves the right to call for additional Documents.</i>	

8. Employment Details:**a. Prior to Disability:**

Name of the Company / Business:	
Designation of Life Assured:	
Exact nature of the job:	

b. Post Disability:

Is the Life assured currently employed?	<input type="checkbox"/> Y	<input type="checkbox"/> N
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If yes, then please give following details:

Name of the Company/ Business:		
Designation of Life Assured:		
Exact nature of the job:		
Department:		
Address:		
City / Town:	Pin code:	Tel No:
If not employed, then date from which the Life assured stopped working:		
Date by which the Life assured is expected to return to work:		
Has the life assured applied for any jobs? If yes, please mention the nature of job application:		

9. Is the Life Assured currently undergoing any rehabilitation program? If yes, please give details such as name of the institute, duration and nature of program:

Name of the Institute	Duration	Nature of Program

10. Particulars of other Life Insurance / Mediclaim / Personal accident policies held by the Life Assured:

Policy No.	1	2	3
Name of the company:			
Commencement date:			
Sum Assured:			
Riders opted:			
Year of Claim			
Cause of Claim			
Amount of Claim			
Status of the Claim:			

■ I, _____ do hereby declare that the above statement is true in each & every respect. I hereby authorize any medical attendant or doctor who had attended to the above named Life Assured or employer / business associate of the Life Assured to provide any information or details as to the state of health and habits of the Life Assured, to the Company, within his /her knowledge before or after this policy was issued.

	Signature of the witness:
	Name of the witness:
	Relationship with the claimant:
(Signature / Thumb impression of Claimant)	
<u>Date:</u> _____ <u>Place:</u> _____	<u>Date:</u> _____ <u>Place:</u> _____
<u>Tel No.:</u> _____	<u>Tel No.:</u> _____

Authorization
(To be signed by the claimant)

To,

Life Insurance Policy Number(s): _____

I, Mr. / Ms. _____ (name), _____ (relation) of Mr. / Ms. _____ (name of the Life Assured) hereby give my consent to M/s ICICI Prudential Insurance Co. Ltd., and / or its representative to obtain all employment / medical / hospital records / other records (including photocopies) / information pertaining to the treatment / occupation of the Life Assured as stated above.

Yours faithfully,

Signature of the Claimant

Date: