Pramerica | LIFE INSURANCE **CRITICAL ILLNESS CLAIM FORM**

The Claims Department,

Pramerica Life Insurance Limited

Please read the instructions mentioned on the last page before filling up this form.

Document's checklist

1. All past and current medical/hospital records - admission notes, test records, discharge summary etc. (where applicable)
2. Original Policy Bond

In connection with Claim under Policy No. _____ for Rs. _____

on the life of _____ I, _____ the claimant

under the Policy make the following statement:

Particulars of the Life Insured

Policy No(s):

Name of the Life Insured:

Title: Mr/Mrs/Ms/Dr. First name Middle name Surname

Date of Birth (D D M M Y Y Y Y) Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Residential Address:

Pin Code:

STD Code Landline Number Mobile Number

E-mail:

Name of Employer:

Employer contact details:

Address:

Pin Code:

STD Code Landline Number Mobile Number

ELECTRONIC PAYOUT OPTION (Direct transfer of funds to your bank account). Please submit original cancelled cheque along with this form. (Account holder's name should be printed on the cheque leaf).

Name of Life Insured/Claimant:

Bank & Branch Name:

Account No.: IFSC Code:

MICR Code:

Declaration: I/We authorize Pramerica Life Insurance Limited to process the proceeds under the Critical illness Claim of the aforesaid policy/s through Electronic Funds Transfer to the above mentioned bank account details. Further the Company reserves the right illness of the aforesaid policy/s through Electronic Funds Transfer to the above mentioned bank account details. Further the company reserves the right to use any alternative Payout action including demand draft/payable at par cheque irrespective of opting for Electronic Payout method. I/We, accept the full responsibility for above mentioned Bank account details. I/We will not hold Pramerica Life Insurance Limited liable for any loss if funds are transferred or not transferred or delayed due incomplete or incorrect or third party banking details provided above.

Signature/Thumb impression of Life Insured/Claimant

Details of critical illness

Nature of critical illness/diagnosis: _____

First complaint of symptoms: _____

Date of first diagnosis: _____

How long has the Life Insured been under treatment?

Details of consultations

Consultation	Name(s) of Doctor/Hospital	Address of Doctor/Hospital	Contact No of Doctor/Hospital	Date	Disease/ Condition
a) The first doctor consulted for this illness					
b) The doctor who referred the Life Insured to hospital for treatment					
c) All other doctors/ hospitals consulted for this/other illness					
d) Usual medical attendant/family doctor					

Any other relevant information:

_____

_____

Authorisation

I/We _____ hereby authorise and give my/our consent to Pramerica Life Insurance Limited and/or its representatives to seek information, obtain all information, records in relation to employment, medical, hospital records, police records, other records (including photocopies) in connection with any treatment, occupation, personal details in connection with this claim.

_____

Signature of the Life Insured

Declaration

I/We hereby declare that the statements made herein above are true and correct. I/ We further declare the written statement of all the physicians, and all papers furnished in support of this claim shall constitute proofs of critical illness. I/We further declare and agree that the furnishing of this form or any other forms supplemental thereto or any acts of enquiry or investigation by Pramerica Life Insurance Limited shall not constitute or be considered as an admission of the claim by the Company.

_____

Signature of the Life Insured

Name, Designation and Address of the Life Insured

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