

**Bajaj Life Insurance Limited**

(Formerly known as Bajaj Allianz Life Insurance Company Limited)

GROUP ACCELERATED CRITICAL ILLNESS CLAIM FORM

This printed form is issued on receipt of notice of Critical illness claim and liability.

All Payments shall be made according to terms and conditions of the policy.

The company retains right to call for further evidence needed to process the claim and to entertain or repudiate the claim.

Acceptance of forms does not amount to admission of claim

**Document Checklist:-**

|  |
| --- |
| a. Claimant’s Statement  b. Complete Hospital treatment records.  c. Certificate of Insurance |

**PARTICULARS OF INSURED:**

|  |  |
| --- | --- |
| Master Policy No(s): | Master Policyholders Name: |
| Members Name: | Occupation/Main Duties: |
| Age: | Customer Identification No: |
| Sex: | Sum Assured: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. | Name | Address | Tel. No. | Fax No. |
| 1. Family physician |  |  |  |  |
| 1. Physician who is treating this illness |  |  |  |  |
| 1. Any other doctor/s & Hospital/s visited Pertaining to the Treatment of this Condition with |  |  |  |  |
| d) Registration number |  |  |  |  |

|  |  |
| --- | --- |
| 2. Date of last visit to doctor: |  |
| 3.a) Diagnosis:  3.b) Name of the investigation with the results confirming diagnosis: |  |
| 4. Date of diagnosis: |  |
| 5. Date of onset of the illness: |  |
| 6. Details of the symptoms experienced:    Progress of the illness:  Recent status of the illness: |  |
| 7. Have you ever been hospitalized for the above mentioned illness    If yes, please provide details, including dates of hospitalisation, name  And address of the hospital, your indoor Reg. No., diagnosis: | Yes/No |
|  |
| 8.Have you ever undergone any surgical procedure for above mentioned illness  If yes, please provide details:   1. Dates of surgery, 2. Name and Address of the hospital, 3. Indoor Reg. No. 4. Diagnosis:   **(Attach case-sheets for the same)** | Yes/No |
|  |
|  |

**RECEIPT OF DISCHARGE FROM INSURED MEMBER**

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_the insured member do hereby solemnly affirm and declare that all the answers to the questions in this report are true to the best of my knowledge and belief and that nothing has been concealed or misrepresented. I also hereby accept that any concealment, misrepresentation or false answers herein shall entitle the company to avoid its liabilities under the policy. I hereby provide discharge in favour of Bajaj Life Insurance Limited towards receipt of the critical illness sum assured of Rs.\_\_\_\_\_\_\_\_\_\_\_\_\_\_ being the critical illness benefit of Mr/Ms\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, client id \_\_\_\_\_\_\_\_\_\_\_\_\_\_ in full & final settlement of the critical illness claim under policy no. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Signature by the claimant across revenue stamp

Name :-

Address:-

Signature by the authorized signatory of MPH

Name :-

Address:-