



3) State the names, address and contact no. of the doctor/s and the Hospital/s in which you were treated for the said dismemberment? Please attach relevant doctor certificates and Hospital admit/discharge card.

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4) Give a detailed description of the circumstances under which you were dismembered, mentioning date, time and place of accident which led to the said dismemberment?

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5) If the dismemberment arose as a result of an accident, name the Police Station where the accident was reported and also mention the case no./FIR. Attach a copy of the FIR and the Final Police Investigation Report certified by the police. If the accident was not reported to the police, please state the reasons thereof and mention the names, addresses and Telephone nos. of the persons who witnessed the accident and your relationship with them, if any.

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**Declaration**

I/We hereby notify Aditya Birla Sun Life Insurance Company Limited (ABSLI) that Mr./Ms./Master \_\_\_\_\_ whose life was insured by the said company, under policy no./ nos. \_\_\_\_\_ is dead and I hereby declare that the said person is the Life Insured described above and that the aforesaid answers and statements made by me are true and correct. I agree that furnishing of this form, or any forms supplemental thereto, shall not constitute nor be considered an admission by Aditya Birla Sun Life Insurance Company Limited (ABSLI) that there was any assurance in force on the life in question or of its liability there under, nor a waiver of any of its rights or defense. I hereby authorize any physician, hospital, clinic, insurance company or other organization, institution or person, that has any record of the deceased or his health, to give to Aditya Birla Sun Life Insurance Company Limited (ABSLI), any and all information about the deceased with reference to his health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. I further authorize the Employers (past and present) of the Life Insured to furnish to Aditya Birla Sun Life Insurance Company Limited (ABSLI), details of the leave availed of by the Life Insured during the last three years of his service together with copies of the leave applications and medical certificates, if any, submitted by the Life Insured in support of such applications and details of reimbursement of medical expenses. I also consent to a personal investigation. I hereby provide my consent to receive a call from ABSLI or if authorized service provider in connection with any matter related to the above policy.

Date: 

D	D	M	M	Y	Y	Y	Y
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 Place: \_\_\_\_\_

Name of Claimant/Policy owner: \_\_\_\_\_

Signature of First Claimant/Policy Owner: \_\_\_\_\_

**Vernacular Declaration:**

Declaration to be made by Third Person where the claimant signs in vernacular or affix a thumb impression or has not filled the form: I hereby certify that the contents of this form were explained to the claimant in \_\_\_\_\_ language and have truthfully recorded the answers provided to me. The claimant has affixed his/her impression in my presence

Date: 

D	D	M	M	Y	Y	Y	Y
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 Place: \_\_\_\_\_

Declarant Name & Signature: \_\_\_\_\_

# Electronic Funds Transfer (EFT) Mandate Form

(Direct Transfer of funds to your bank account)

Account Holder Name: \_\_\_\_\_

(As mentioned in Bank Account)

Bank Name: \_\_\_\_\_ Branch Name: \_\_\_\_\_

Type of Bank Account: \_\_\_\_\_ Bank Account Number:

Branch Address: \_\_\_\_\_

MICR Code:  (9 digit code as appearing on the cheque copy issued by bank)

IFSC code (Indian Financial Security Code):

**Note:** Please attach Pre Printed Cancelled Cheque bearing the above mentioned Account Number and IFSC Code along with this form. In case of non-availability of Pre Printed Cheque, ABSLI requires a bank statement or a Printed Bankers Authorization in original containing aforesaid details duly seal and signed by Bank Branch Manager

In case of submission of incomplete / incorrect form Company will not transfer the Claim Proceeds Electronically and provide an account payee cheque mentioning account number and bank name if provided in the mandate or else company will draw an account payee cheque in case of admissibility of claim.

## Declaration:

I / We hereby

- Declare that the details provided as above are correct and complete.
- Authorize ABSLI to process the proceeds under the death claim of the aforesaid policy/s through EFT to the above mentioned account details
- Agree to not hold Aditya Birla Sun Life Insurance Company Limited (ABSLI) or its associate / agent responsible in case of any non-credit to my bank account or if the transaction is delayed or not effected at all for reasons of error/misrepresentation/incomplete/incorrect information furnished by me in this EFT mandate

Date:

\_\_\_\_\_  
Life Insured's Signature

## Declaration by Life Insured:

I hereby notify the Aditya Birla Sun Life Insurance Co. Ltd. that Mr./Ms./Master \_\_\_\_\_ whose life is insured with ABSLI is suffering from \_\_\_\_\_. I hereby declare that the above and that the aforesaid answers and statements made by me are true and correct. I agree that furnishing of this form, or any forms supplemental thereto, shall not constitute nor be considered an admission of claim by Aditya Birla Sun Life Insurance Co. Ltd. that there was any assurance in force on the life in question or of its liability thereunder, nor a waiver of any of its rights or defense. I hereby authorize any physician, hospital, clinic, insurance company or other organization, institution or person, that has any record of the my health, to give to Aditya Birla Sun Life Insurance Company Limited, any and all information about my health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. I further authorize the Employers (past and present) of the Life Insured to furnish to Aditya Birla Sun Life Insurance Company Limited, details of the leave availed of by the Life Insured during the last three years of his service together with copies of the leave applications and medical certificates, if any, submitted by the Life Insured in support of such applications and details of reimbursement of medical expenses. I also consent to a personal investigation. I agree that payment of claim amount shall constitute discharge of liability of ABSLI. I agree that payment of claim amount shall constitute discharge of liability of ABSLI. I hereby provide my consent to receive a call from ABSLI or its authorized Service Providers in connection with any matter related to the above policy.

Date:

Place: \_\_\_\_\_

\_\_\_\_\_  
Signature of Life Insured

\_\_\_\_\_  
Signature of Policy Owner

## Aditya Birla Sun Life Insurance Company Limited

(Formerly known as Birla Sun Life Insurance Company Limited)

Regn. No.: 109. Regd Office: One Indiabulls Centre, Tower 1, 16th Floor, Jupiter Mill Compound,

841, Senapati Bapat Marg, Elphinstone Road, Mumbai - 400013

+91 22 6723 9100 | claims.lifeinsurance@adityabirlacapital.com | www.adityabirlasunlifeinsurance.com | CIN: U99999MH2000PLC128110

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and used by ADITYA BIRLA SUN LIFE INSURANCE COMPANY LIMITED (ABSLI) under the license

Contact Us:

1-800-270-7000

adityabirlacapital.com





## To be completed by Attending Physician – Part B

Policy Number:

Name of Life Insured: \_\_\_\_\_

Date of Birth:         Age:

Occupation: (including description of duties): \_\_\_\_\_

Last day at work: \_\_\_\_\_ Qualification: \_\_\_\_\_

Any identification Marks: \_\_\_\_\_

Admission Date:         Time:     AM/PM Place: \_\_\_\_\_

Hospital Name: \_\_\_\_\_

Hospital Address: \_\_\_\_\_

Patient History: \_\_\_\_\_

\_\_\_\_\_ Discharge Date:

### Examination and Diagnosis:

1) Kindly describe in brief the nature of injuries noticed on examination?

\_\_\_\_\_  
\_\_\_\_\_

2) Was the nature of injuries noticed on examination consistent with the history reported on consultation/admission? If not, please state what in your opinion could have caused the injuries.

\_\_\_\_\_  
\_\_\_\_\_

3) What was the final diagnosis and when was the patient informed of the same?

\_\_\_\_\_  
\_\_\_\_\_

4) Kindly state the nature of deformity, injury in brief, which contributed to the causes leading to dismemberment?

\_\_\_\_\_  
\_\_\_\_\_

### Treatment:

1) Kindly give particulars of treatment given?

\_\_\_\_\_  
\_\_\_\_\_

2) What is the present condition of the patient?

\_\_\_\_\_

3) In your opinion is the patient unable to follow his usual vocation and if so, please state why?

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4) Kindly state the percentage of dismemberment?

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5) Which parts of the body are affected due to injury?

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6) In your opinion, what would be the time required for the patient to recover fully from the dismemberment?

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7) Have you any information or remarks to make concerning the ailments, habits or way of living of the patient which may have a bearing on the dismemberment?

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Name of Doctor: \_\_\_\_\_ Registration Number: \_\_\_\_\_

Postal Address: \_\_\_\_\_

Landline No.:

Mobile No.:

Email address: \_\_\_\_\_ Qualification: \_\_\_\_\_

**Declaration**

I/We hereby certify that the above information is true and correct as per the records maintained by me/hospitals. I hereby provide my consent to receive call from Aditya Birla Sun Life Insurance Company Limited (ABSLI) or its authorized Service Providers in connection with any matter related to this Policy.

Full Signature of Doctor: \_\_\_\_\_ Date of Report:

Any confidential information, which in your opinion should be in the possession of the Company, should be forwarded to Head Office at the below mentioned address.