

WITHOUT PREJUDICE

LIFE ASSURED'S STATEMENT – CRITICAL ILLNESS

Affix Life Assured's Photograph and Sign Across

Policy Number(s):										
Name of the Life Assured:										
Address of the Life Assured:										
		Tel. No								
Bank Account No.:	Bank	Name:								
Address of Bank:										
In case the claim is admitted, I agree for direct deposit of claim amount into my Bank Account: (Tick the option you want to choose)										
IMPORTANT: The person filling the form must be the Life Assured / Life Assured of the policy(s). If the space in the box is inadequate, kindly attach Annexure										
	PART 1 – INFORMATION REGA									
Date on which Life Assured consulted the doctor for first time for the illness:										
Name of the tests performed	:									
Illness Diagnosed	:									
Date of Diagnosis : D D M M Y Y Y Y										
Usual Medical Attendant's Name a	nd Address:									
Usual Medical Attendant's Telepho	ne Number:									
	PART 2 – EMPLOYMI	ENT DETAILS								
Employer's Name and Address:										
		_ _ _								
Designation at work place:										
Employer's Telephone Number:		_								
Date left employment, if any:	D D M M Y Y Y									
PART 3 – DETAILS OF SPECIALIST/DOCTOR/HOSPITALTREATING THE LIFE ASSURED										
Please specify details of the specialist consulted (Cardiologist/Oncologist/Nephrologists/Neurologist/any other specialist, please specify):										
Name:										
Address:										
		Telephone Number:								
Name and address of the Hospital he/she is attached:										
		Number of the User Web								
Telephone Number of the Hospital:										

SBI Life Insurance Company Limited: Registered and Corporate Office: Natraj, M.V. Road & Western Express Highway Junction, Andheri(East), Mumbai- 400 069. Tel.: (022) 61910000. Central Processing Center: 7th Level (D-Wing) & 8th Level, Seawoods Grand Central, Tower 2, Plot No. R-1, Sector-40, Seawoods, Nerul Node, Navi Mumbai- 400 706. Tel.: (022) 66456000. IRDAI Registration No. 111. CIN: U99999MH2000PLC129113. Toll Free No. 1800 22 9090 (From 9.00am to 9.00pm). Visit: www.sbilife.co.in E-mail: info@sbilife.co.in



Please specify details of the operating surgeon, if any surgery has been performed:												
Name:												
Address:												
	Telephone Number:											
Name and address of the Hospital he/she is attached:												
	elephone Number of the Hospital:											
I.P. No. : Date of Admission:	M M Y Y Y Date of Discharge : D D M M Y Y Y Y											
PART 4 – INFORMATION ON	NOTHER INSURANCE POLICIES											
A. Policy Number/s:												
Sum Assured: ₹												
Insurance Company Name:												
B. Policy Number/s:												
Sum Assured: ₹												
Insurance Company Name:												
PART 5 –	DOCUMENTS											
 - Admission notes and discharge summary from the treating hospital /s - All test reports such as blood test, X – Ray, ECG, CT scan and surgery notes - Certificate by treating doctor / hospital Note: The Company reserves the right to call for additional documents 												
PART 6 –	DECLARATION											
Note – In the event the Life Assured with Illness is unable to con	nplete this form, ignore Part 6. Part 7 should be completed.											
	by declare that this statement made here in above is true in each and											
every respect.	ated me for any allment or illness and my Employer or its officers or any											
I authorize the Hospital/s and Doctor/s, who have examined or treated me for any ailment or illness and my Employer or its officers or any other person to provide information regarding the Illness which they may have acquired before or after the policy was issued by SBI Life Insurance Co. Ltd., to the Company and its officers.												
I agree to provide and furnish details and reports as and when require	ed by SBI Life Insurance Co. Ltd. for processing this critical illness claim.											
	Signature of the witness: Name of the witness:											
(Signature / Thumb Impression of Life Assured)	Relationship with the Life Assured:											
Date : D D M M Y Y Y Y Date : D D M M Y Y Y Y												
Place :												

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This declaration must be witnessed by an Advocate, Bank Manager, Block Development Officer, Commissioner of Oaths/Notary, Doctor, Gazette Officer, Head Master of a High School, Head Post Master or Departmental Sub-Post Master, Magistrate or President of a Village or Local Body or SBI Life officers above Asst. Manager designation. If the declarant signs in vernacular or affixes a thumb impression, the witness should also sign the following. I certify that the contents of this form were explained to the Life Assured in (language) and he/she has affixed his/her thumb impression after fully understanding the same. Date: DDDMMMYYYYY Signature of Witness **PART 7 - DECLARATION** Note - This should only be completed if the Life Assured with illness is unable to complete this form. , do hereby declare that this statement made here in above is true in each and every respect. On behalf of _ _ (the Life Assured), I authorise the Hospital and Doctor/s who have examined or treated (the Life Assured) for any ailment or illness and his/her Employer and its officers or any other person to provide information regarding the Illness which they may have acquired before or after the policy was issued by SBI Life Insurance Co. Ltd., to the Company and its officers. (the Life Assured), I agree to provide and furnish details and reports as and when required by SBI Life Insurance Co. Ltd. for processing this critical illness claim. Signature of the witness: Name of the witness: _ Relationship with the Life Assured: (Signature / Thumb Impression of Life Assured) Date Date : D D M M Y Y Y Y : D D M M Y Y Y Place Place Telephone No. : Telephone No.: This declaration must be witnessed by an Advocate, Bank Manager, Block Development Officer, Commissioner of Oaths/Notary, Doctor, Gazette Officer, Head Master of a High School, Head Post Master or Departmental Sub-Post Master, Magistrate or President of a Village or Local Body If the declarant signs in vernacular or affixes a thumb impression, the witness should also sign the following. I certify that the contents of this form were explained to the Life Assured in __ (language) and he/she has affixed his/her thumb impression after fully understanding the same. Date: DDMMMYYYYY Signature of Witness

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WITHOUT PREJUDICE

PART 8 - AUTHORISATION

(To be signed by the Life Assured)

		(10 00 01	griod by the	Elio / toodi od)				
To,								
I, Mr/Ms Insurance Co.Ltd., and/ records/information perta	or its represen	tative to obtain (including pl	name of the Li	fe Assured) the employ	hereby give /ment/medica	my consent to al/hospital recor	SBI Life
Yours faithfully,								
Name of the Life Assured	<u>:_ </u>				_			
Policy No.	:					Signature of	the Life Assured	t
Date	: D D M I	<u> </u>						
		PART 9	– NOTE OF	AUTHORITY				
ı				(Life Assu	ıred Name) h	nereby reque	st/authorize M/S	SBII ife
					•			
Insurance Company Limi of		Bank at			_Branch		(Branch	Code)
Name of the Life Assured	1.						Affix Revenue stamp and sign across	
Name of the Life Assured						— Signat	ure of the Life As	ssured
						3 3		
Osserta a Oisea a de								
Counter Signed:				5				
Name:								
SS. No.:								
Address:								

(To be counter signed by the Bank officer where the Life Assured holds his/her account)

Note:

- This note of authority is purely optional
- This form is sent only for the convenience of the Life Assured
- This note of authority will be considered by SBI Life Insurance Company Limited if and only if the claim has been admitted by SBI Life Insurance Company Limited.
- A mere receipt of this blank form shall not give any right to the Life Assured to deem that the claim has been/will be admitted by the SBI Life Insurance Company Limited.

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