

## **TOTAL AND PERMANENT DISABILITY CLAIM FORM**

In connection with Po	licy	Nui	mbo	er/s	:																							
Claim Number (For Office Use only) :																												
Name of the Life Assure	ed:																											
Address of the Life Assu	ured		[					[					L											L				
		[	[			[		[							[	[			Tel.	No.				L				
Bank Account No.:								[				IFS	C Co	ode:														
Bank Name																								L				
Address of Bank:			[	[	[			[						[			[											
													L															
Name of the Claimant :																												
Address of the Claimant	: [					[		[							[	[												
															[	[		-	Tel.	No.								
	MPORTANT: The person filling the form must be the Life Assured/ claimant of the policy(s). If the space in the box is inadequate, kindly attach Annexures  PART 1 – INFORMATION REGARDING THE LIFE ASSURED															te,												
Kind of Disability:																												
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Place of Accident:																				. L		. L	. L	_ L	L			
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Date of Accident:  Last Home Address:  Name of Employer:  Address & Tel. Nos.  of the Employer Last employed with:	STS	L L					 		Γ2.		L L L	COR	INF	OR					AN	//PN	// // // // // // // // // // // // //							
Date of Accident:  Last Home Address:  Name of Employer:  Address & Tel. Nos.  of the Employer Last employed with:  DETAILS OF SPECIALI	STS	L L					 		Γ2.		L L L	COR	INF	OR					AN	//PN	// // 							
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Date of Accident:  Last Home Address:  Name of Employer:  Address & Tel. Nos.  of the Employer Last employed with:  DETAILS OF SPECIALI  1) Name of Doctor/Hosp	STS	L L					 		Γ2.		L L L	COR	INF	OR					AN	//PN	//							
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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: L99999MH2000PLC129113. Toll Free No. 1800 267 9090 (Customer Service timing: 24X7). Visit: www.sbilife.co.in E-mail: info@sbilife.co.in

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2) Name of Doctor/Hos	pital:														
Address & Tel. Nos.:															
Dates of consultation:		-													
Nature of consultation:															
-															
3) Name of Doctor/Hos	pital:														
	·														
Address & Tel. Nos.:															
Dates of consultation:															
PART 3 – CAUSE OF ACCIDENT															
	f it is a road accident, state the following: If it is any other form of accident and not avehicular accident, then you may keep the information relating to 2, 3 and 4 blank.														
1. Type of Accident:	,														
,,,															
2. Make and registration	n numbers of vehicles involved:														
3 Name Address & Tel	Nos. of registered owners:														
o. Name, Address & Tel.	TVOS. OF Teglotered Owners.														
4. Names, Addresses &	Tel. Nos. of drivers:														
5. Names, Addresses &	Tel Nos														
of other persons involv															
6. Names, Addresses &															
of all witnesses to acci	ident:														
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7. Date and time of admittance to hospital:	
8. Name, Address & Tel. Nos. of hospital:	
9. Details of attending doctors:	
10. Names, Address & Tel. Nos of police station where Accident reported:	
11. Name of police officers who	
conducted investigations:	
12. Details of their findings (Please send copy of report if available):	
(Flease seria copy of report if available).	
DART 4 DETAIL O	E ALL OTHER INQUIRANCE COVER / OLAHAR
	F ALL OTHER INSURANCE COVER / CLAIMS
Please provide us with Company Names, Addresses	s, Policy Numbers, Claim Number:
Company Names	
Addresses	
	Tel. No:
Policy Numbers	Claim Number:
D   D   M   M   Y   Y   Y   Y	
Date:	
Place:	
Name of Branch Manager	
	Signature of the Branch Manger
	(Duly Signed and Stamped)

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## **PART 5 - DECLARATION** Note - In the event the Life Assured with disability is unable to complete this form, ignore Part 5. Part 6 should be completed. do hereby declare that this statement made Here in above is true in each and every respect. I authorize the Hospital/s and Doctor/s, who have examined or treated me for any ailment or illness/disability and my Employer or its officers or any other person to provide information regarding the Illness/disability 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 required by SBI Life Insurance Co. Ltd. for processing this critical illness claim. Declared at: \_ Signature / Thumb impression Name in Block Letters: | D | D | M | M | Y | Y | Y | YDate: 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 Date: D D M M Y Y Y Y Signature of Witness: Name in Block Letters: Designation: Address: Telephone Number: If the Claimant signs in vernacular or affixes a thumb impression, the witness should also sign Signature of Witness: I certify that the contents of this form were explained to the Claimant in (language) and he/she has affixed his/her thumb impression after fully understanding the same. **PART 6 - DECLARATION** Note - This should only be completed if the Life Assured with disability is unable to complete this form.

I \_\_\_\_\_\_ 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.

On behalf of \_\_\_\_\_\_ (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.

## **Aadhaar Consent:**

I, < Name of the Customer> , hereby give my voluntary consent to SBI Life Insurance Company Limited (SBI Life) and authorise the Company to obtain necessary details like Name, DOB, Address, Mobile Number, Email, Photograph through the QR code available on my Aadhaar card / XML File shared using the offline verification process of UIDAI. I understand and agree that this information will be exclusively used by SBI Life only for the KYC purpose and for all service aspects related to my policy/ies. I have duly been made aware that I can also use alternative KYC documents like Passport, Voter's ID Card, Driving licence, NREGA job card, letter from National Population Register, in lieu of Aadhaar for the purpose of completing my KYC formalities. I understand and agree that the details so obtained shall be stored with SBI Life and be shared solely for the purpose of issuing insurance policy to me and for servicing them. I will not hold SBI Life or any of its authorized officials responsible in case of any incorrect information provided by me. I further authorize SBI Life that it may use my mobile number for sending SMS alerts to me regarding various servicing and other matters related to my policy/ies.

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Declared at: _																																	
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- Disability Certificate Issued by appropriate Authority
- Original Policy Document
- Copy of FIR
- Leave records for past 6 months from the employer. (Where applicable)
- Copy of Hospital Indoor case papers and treatment reports.

<sup>\*</sup> Company reserves the right to call for any other document other than the ones mentioned above at its discretion.