SBI Life
Apne liye. Apno ke liye.

TOTAL AND PERMANENT DISABILITY CLAIM FORM

In connection with Policy Number/s :

Claim Number (For Office Use only) :

Name of the Life Assured:

Address of the Life Assured:

Tel. No.

Bank Account No.: IFSC Code:

Bank Name

Address of Bank:

Name of the Claimant :

Address of the Claimant :

Tel. No.

IMPORTANT: 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

Kind of Disability:

Place of Accident:

Date of Accident: D D M M Y Y Y Y Exact Time of Accident: AM/PM

Last Home Address:

Name of Employer:

Address & Tel. Nos. of the Employer Last employed with:

PART 2 – DOCTOR INFORMATION

DETAILS OF SPECIALISTS/DOCTORS/HOSPITALS TREATING THE LIFE ASSURED

1) Name of Doctor/Hospital:

Address & Tel. Nos.:

Dates of consultation: D D M M Y Y Y Y

Nature of consultation:

2) Name of Doctor/Hospital:

Address & Tel. Nos.:

Dates of consultation: D D M M Y Y Y Y

Nature of consultation:

3) Name of Doctor/Hospital:

Address & Tel. Nos.:

Dates of consultation: D D M M Y Y Y Y

Nature of consultation:

PART 3 – CAUSE OF ACCIDENT

If 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 numbers of vehicles involved:	
3. Name, Address & Tel. Nos. of registered owners:	
4. Names, Addresses & Tel. Nos. of drivers:	
5. Names, Addresses & Tel. Nos. of other persons involved (if available)	
6. Names, Addresses & Tel. Nos. of all witnesses to accident:	

7. Date and time of admittance to hospital:	D D M M Y Y Y Y AM/PM
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):	

PART 4 – DETAILS OF ALL OTHER INSURANCE COVER / CLAIMS

Please provide us with Company Names, Addresses, Policy Numbers, Claim Number:

Company Names

Addresses

Tel. No:

Policy Numbers

Claim Number:

Date: D D M M Y Y Y Y

Place:

Name of Branch Manager

Signature of the Branch Manger
(Duly Signed and Stamped)

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.

I _____ 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: _____

Name in Block Letters:

Date: D D M M Y Y Y Y

Signature / Thumb impression

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

Name in Block Letters:

Designation:

Address:

Telephone Number:

Signature of Witness:

If the Claimant 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 Claimant in _____ (language) and he/she has affixed his/her thumb impression after fully understanding the same.

Signature of Witness:

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.

Declared at: _____

Name in Block Letters:

Relationship to the Life Assured :

Date: D D M M Y Y Y Y

Signature

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 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 Claimant in _____ (language) and he/she has affixed his/her thumb impression after fully understanding the same.

Signature of Witness:

PART 7 – DOCUMENTS

Please provide the following original documents. If not provided, please state the reasons therefore.

Documents Required

- 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.

*** Company reserves the right to call for any other document other than the ones mentioned above at its discretion.**