Claim Form A - Total Permanent Disability

Policy No.

Date D D M M Y Y Y Y

(All answers in BLOCK LETTERS and No Dots & Dashes)

Name of the Life Assured FIRST LAST

Correspondence Address/ Usual place of residence FLAT NO. BUILDING

ROAD NAME/NO. LANDMARK 1

DISTRICT/TALUKA LANDMARK 2

CITY/VILLAGE STATE Pincode

STD ISD Code LANDLINE MOBILE EMAIL ADDRESS

Date of Birth D D M M Y Y Y Y Date of disability D D M M Y Y Y Y

Phone number

If disability is the result of an accident, state where and how did it occur

Nature of illness Date when the symptoms first developed D D M M Y Y Y Y

Date last worked D D M M Y Y Y Y

Are you still totally disabled? Yes No

Type of employment in which you are engaged

Have you been able to perform any work since the onset of disability? Yes No

Please provide name(s), address(es) of all medical practitioners who have treated you during your current disability and the date(s) of all such treatment(s)

Name FIRST LAST

Address FLAT NO. BUILDING

ROAD NAME/NO. LANDMARK 1

DISTRICT/TALUKA LANDMARK 2

CITY/VILLAGE STATE Pincode

STD ISD Code LANDLINE MOBILE EMAIL ADDRESS

Date of treatment D D M M Y Y Y Y

Please provide name(s), and address(es) of all hospital(s) in which you were treated during your current disability and the date(s) of all such treatment (s)

Name(s) of hospital(s)

Address(es) ROAD NAME/NO. LANDMARK 1

DISTRICT/TALUKA LANDMARK 2

CITY/VILLAGE STATE Pincode

STD ISD Code LANDLINE MOBILE EMAIL ADDRESS

Date of treatment D D M M Y Y Y Y

If you have any other insurance which provides disability benefits, please give name of company(ies) and policy number(s)

Earnings as of date of disability

Treatment dates

Date of first visit for current condition D D M M Y Y Y Y Date of most recent visit D D M M Y Y Y Y

Frequency of visits Weekly Monthly Other

Nature of treatment

Medications (including prescribed dosages)

Surgeries (completed or anticipated)

Other

Current Status: Neurological

Physical Status:

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Bank Account Details of Claimant/Appointee in case the proposer died in the laspe period (Please note that all the payments would be made only through direct transfer to the Bank Account, hence cancelled cheque is to be attached)

Name as per Bank Records FIRST LAST

BANK NAME BRANCH NAME

ACCOUNT NO. IFSC CODE

I am enclosing herewith

☐ The Original Policy Document/s ☐ Doctor/Hospital Certificate/s ☐ Cancelled cheque & bank passbook/bank statement ☐ Disability Certificate

☐ FIR Copy/Police Records ☐ Others

I hereby declare that the statements made in this claim form by me are true and correct to the best of my knowledge and belief.

Signature of the Life Assured

Signature of the Witness

Date D D M M Y Y Y Y

Name of the Witness FIRST LAST

Address FLAT NO. BUILDING

ROAD NAME/NO. LANDMARK 1

DISTRICT/TALUKA LANDMARK 2

CITY/VILLAGE STATE Pincode

STD ISD Code LANDLINE MOBILE EMAIL ADDRESS

Declaration by the person completing this claim form

Reliance Nippon Life Insurance requires that this form is completed by the Life Assured. If this is not possible because the Life Assured does not read, write or speak English, then this form may be completed by another person who must complete the following declaration.

I have explained the contents of this form to the Life Assured and endeavoured to ensure that the contents have been fully understood. I have accurately recorded the responses to the information sought by this Claim Form and I have read the responses back to the Life Assured and confirmed that they are correct.

Name of the Declarant FIRST LAST

Occupation

Address FLAT NO. BUILDING

ROAD NAME/NO. LANDMARK 1

DISTRICT/TALUKA LANDMARK 2

CITY/VILLAGE STATE Pincode

STD ISD Code LANDLINE MOBILE EMAIL ADDRESS

Signature of the Declarant

For Internal use: To be filled by the Branch

Name of the Person to whom form was issued

Relationship with the Life Assured

Claim Form Issue Date D D M M Y Y Y Y

Name of the Issuing Officer

Date of receiving Claim Form at Branch D D M M Y Y Y Y

CIN: U66010MH2001PLC167089 CLAIMS/FormA-TPD/Version 1.4/April2018