

**CLAIMANTS STATEMENT
For Reimbursement Claim**

Notes (1): To be filled in by the person legally entitled to the policy proceeds

(2): Incomplete forms will not be accepted

(A) Life Insured's Details (whose claim has been lodged)

Policy No.(s): _____ Name of the Life Insured in full: _____

Age: _____ Occupation: _____ Contact No: (Res) : _____ Mobile: _____

Business Tel: _____ Email id: _____

Address for correspondence:

Name of the TPA(Third Party Administrator): _____ TPA ID No: _____

(B) Policy Owner Details (i.e. the person in whose name the Policy is issued)

Name of the Policy Owner: _____ Relationship to Life Insured: _____

Contact No: (Res) : _____ Mobile: _____

Business Tel: _____ Email id: _____

Address for correspondence:

(C)Policy Owner's Bank Account Details (Please furnish details of Policy Owner's Bank Account in case the Life Insured and the Policy Owner are different)

Bank Account Number of the Policy owner : _____

Bank Name: _____

Bank Branch Name & Address: _____

(Please furnish the copy of Passbook/Bank Statement containing above details)

Details of Hospitalisation

Name and address of the hospital where admitted: _____
_____ IP No: _____

Date of admission: _____ Time of admission: _____ hrs _____ mins Date of Discharge: _____ Time of discharge _____ hrs _____ mins

No. of days in ICU, if any, with dates _____ Cause of event : _____

Hospitalisation due to: Injury Illness Substance Abuse Alcohol consumption

If injury, give cause: Self inflicted Road Traffic Accident Date of injury / onset of illness: _____

Tick as applicable and provide a copy of Medico Legal Certificate Police FIR

1. (a) What is the occupation of the Life Insured ? _____

(b) Employer's/ Life Insured's business Address: _____

2(a) Is the Life Insured a smoker? Yes No

(b) If yes, since when & mention consumption per day _____

(c) Is the Life Insured consuming alcohol? Yes No

(d) If yes, since when & mention consumption per day _____

3. (a) Has the Life Insured previously suffered from/ had complaints of any similar or related condition? Yes No

(b) If yes, since when the Life Insured has been suffering and nature of complaints/illness _____

4. Has the Life Insured consulted any Doctor for the above complaints and if yes, please mention details & the date of first consultation

5. Date of 1st diagnosis and investigations undergone: _____

6. If the Life Insured has ever fallen ill, state the nature and the duration of illness with date of diagnosis and names of doctors consulted in the last 3 years. (Please provide self attested copies of all the medical reports)

Date of Consultation	Name of treating Doctor / hospital & Address	Nature of complaint	Date of Diagnosis

7. Is the Life Insured covered under any other Life insurance/ Health insurance/ Medi-claim/ Personal accident insurance with any other insurance company? If yes, give following details.

Policy No.	Policy issue date	Name of Insurance company	Total Cover	Has the Claim been lodged (Yes/ No)	Benefits Received (Yes / No)

PEP – State whether the Policy owner is a Politically Exposed Person Yes No

PEP. “Individuals who are or have been entrusted with prominent public functions, for example Heads of State or government, senior politicians, senior government, judicial or military officials, Senior executives or state – owned corporation and important political part officials. Business relationships with family members or close associates of PEP’s involving reputation risk is similar to those with PEP’s themselves”

Date:

To,

DECLARATION AND AUTHORISATION BY THE POLICY OWNER / LIFE INSURED

I /We _____ & _____ do hereby declare that the statements made and details given above by me /us are true, complete and correct. I /We understand and agree that furnishing of this form, or any forms supplemental thereto, shall not constitute nor be considered as an admission by Birla Sun Life Insurance Co. Ltd. that there was any assurance in force on the life in question or of the company's liability thereunder, nor a waiver of any of its rights or defense.

I/We agree that the Company may, in its sole discretion, carry out such investigation/s as it may consider expedient in respect of the claim lodged by me/us.

I /We hereby authorize any physician, hospital, clinic, insurance company or other organization, institution or person, that has any record of the Life Insured or his / her health, to give to Birla Sun Life Insurance Company Limited, or any of its authorized representatives any and all information about the Life Insured with reference to his /her health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment without requiring my presence in person by these authorities. I further authorize the employers (past and present) of the Life Insured to furnish to Birla Sun Life Insurance Company Limited or any of its authorized representatives, details of the leave availed of by the Life Insured during the last three years of his/her 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 the reimbursement of medical expenses. I also consent to a personal investigation.

Date _____ Place _____

Signature of Life Insured _____

Signature of /Policy Owner _____

Witness: Name: _____

Witness Signature: _____

Birla Sun Life Insurance Company Limited
6th Floor, Claims Dept., G-Corp Tech Park, Kasarvadvali, Ghodbunder Road, Thane (W)-400601.
Email: BSLI.Healthhelpline@birlasunlife.com Tel. No. 022- 39961000

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