

Policy No.



**CLAIM FORM - CRITICAL ILLNESS/
ACCIDENTAL DISMEMBERMENT / PERMANENT TOTAL DISABILITY**

KAL PAR CONTROL

Date

The particulars of the Claim Form is to be filled by the Life Insured. In case the Life Insured is unable to fill in the details on medical grounds, then the particulars are to be filled by the Medical practitioner who has attended upon /treated the Life Insured for the ailment /illness.

Section - I

Name of the Life Insured

Particulars of the Claimant

Name of the Claimant:

Date of birth Occupation

Address

Contact no. e- mail id.

Name of the employer ,address and contact details

Method of payment of claim **Cheque/NEFT:** In case you opt for payment through NEFT please submit the enclosed NEFT form duly verified by the bank along with cancelled cheque. In case any information is missing in NEFT form, payment will be made by cheque.)

Claimant's Bank A/c details Bank A/c No. Bank Name:

Section - II Claim Details :

Nature of illness

Date of first consultation in connection with the illness

Have you previously suffered from or received treatment for the same/ other illness ? Yes No
(If yes Please give the date of illness and treatment undergone. Enclose Hospital Records.)

Name & Address of Physician who referred you to the Hospital for current illness.

Part A : To be Completed in case of Critical Illness Claim

Hospitalization Date	Name of Hospital/ Institution	Name of Attending Physician	Treatment Undergone	Nature of Hospitalization (ICU/ Normal)	Date of Discharge	Post Discharge Treatment/ Medication/ Therapy
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

(Please attach all the medical reports)

Part B : To be completed in case of Accidental Dismemberment/ Permanent Total Disability Claim

Date of Accident/ Hospitalization	Name of Hospital/ Institution	Name of Attending Physician	Nature of Disability	Cause of Disability	Date of Discharge	Post Discharge Treatment/ Medication/ Therapy

(Please attach all the medical reports)

Section - III

Details of other policies (Including Medical Insurance Policies)

Policy No.	Sum Insured	Name of Issuing Company	Date of Commencement	Rider Coverage (If Any)

Declaration :

I hereby declare that all answers given by me in this statement are, to the best of my knowledge and belief, true and complete. I hereby consent to Aviva Life Insurance seeking medical information from the doctor who has attended me concerning anything which affects my physical and mental health or any other evidence they may require in connection with my claim.

I do not wish to see the report and I authorize such a report to be sent to the company

I wish to see the report before it is sent to the company

(Please tick one box only)

Signature of the claimant

*Countersigned By:
(Signature & Stamp)

Address

Designation

Address

Date

Date

* Certified that the contents of this form were explained to the declaration ion vernacular and he/she has affixed his/her thumb impression hereto after fully understanding the same.

Signature of witness

Designation :

Address :

Date

* This statement must be countersigned by : (1) An Advocate (2) A Bank Manager (3) Gazetted Officer (4) A Magistrate (5) Medical Practitioner (6) President of A Village Panchayat or Local Board

Aviva Life Insurance Company India Ltd.
 3rd Floor, Aviva Towers, Sector 43, Opposite DLF Golf Course, Gurgaon - 122 003 Haryana India
 Tel. +91(0)124 2709278 Fax +91(0)124 2571205 www.avivaindia.com
 Registered Office : 2nd Floor Prakashdeep Building 7 Tolstoy Marg New Delhi 110001 India

NEFT MANDATE

Name: Account Type (saving/Current):

Bank Account No.

Name & Address of

Bank:

Bank Branch MICR Code no.

Bank branch IFSC code

no.

I/We confirm that information provided above is correct & any consequences due to to any mistake in above will be borne by us.

Name & Signature of the Claimant:

We confirm that we are enabled for receiving NEFT credits and we further confirm that the account number of
the signature of the authorized signatory and the MICR and IFSC codes of our branch mentioned above are correct.

Bank's verification:

(Manager's/Officers signature under bank Stamp)

.....

Document check List

S. No.	Claim due to illness / surgery	Yes	No
1	Authorization form duly filled and signed (as per the format)		
2	Claim form duly filled		
3	Original policy schedule		
4	Daily records of treatment during hospitalization		
5	Discharge summary from the hospital stating the proper diagnosis and date & time of admission and discharge		
6	All laboratory and pathology tests conducted such as blood reports		
7	All investigative tests such as X-Ray, scans, MRI etc.		
8	Relevant questionnaire duly filled (as per the format)		
9	Declaration by the attending physician on the insured's current state of health		
10	In case of surgery: surgical notes		
11	Final hospital bill including details of room charges (ICU/Normal) and OT charges as well		
12	NEFT Mandate, cancelled cheque (Only if payment opted through NEFT)		
13	Savings Bank account number		
	Claim due to accident		
	In case of accidents in addition to the above mentioned documents, the following are also required:		
1	Copy of FIR		
2	Police Final Report		
3	News paper cuttings (if any)		

AUTHORIZATION
(To be filled & signed by the Life Assured)

Life Insurance Policy No.(s) _____

I, Mr. / Mrs / Ms. _____ (*name of the claimant*), hereby give my consent to M/s Aviva Life Insurance Company India Limited, and / or its representative to obtain all employment / medical / hospital records / police records / other records (including photocopies) / information pertaining to my treatment / occupation which I might have acquired whether before or after the policy was issued by the Company.

Date:

Yours faithfully

Place:

(Signature of Claimant)

Contact details of the claimant:

Address:

Pin: _____

Landline: STD Code _____ No. _____

Mobile: _____

Email id:

