

CLAIMANT STATEMENT FORM (RIDER CLAIM):
FORM (A-2)

Without prejudice

- The form needs to be completed by the Life Assured/Beneficiary under the policy
- Please ensure all questions are answered. Ensure use of "Not Applicable" (N/A) instead of leaving it blank
- Claim proceeds are payable as per terms & conditions mentioned in the policy document and subject to the policy being in force as on the date of event
- Early & Complete submission of requirements would enable the company to process claims at the earliest
- The company reserves the right to call for additional documents / requirements
- Kindly submit the copy of the Discharge Summary / Indoor medical records along with this form

Submission of ID proof of the claimant is mandatory along with this form

Policy No.:

Particulars	Details of the Life Assured
Name	Mr./Mrs./Master/Ms. _____
Address	_____ _____ _____ Pin Code: _____
Tel. No.:	_____

Details of the Claim	
Rider under which the claim is being made	<input type="checkbox"/> CI Rider <input type="checkbox"/> ATPD <input type="checkbox"/> HCB <input type="checkbox"/> WOP <input type="checkbox"/> PWB
Illness diagnosed	_____
In case of claim under CI or HCB please provide the following:	
Date of diagnosis	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Name & address of the doctor who diagnosed the illness	_____ _____ _____ Tel. No.: _____
Name of the hospital where the Insured was admitted	_____
Date of admission:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (Indoor patient no: _____)
Date of discharge	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Symptoms related to current illness	_____ _____
Duration of the said symptoms	_____
Progress	<input type="checkbox"/> Improved <input type="checkbox"/> Recovered <input type="checkbox"/> Unimproved
In case of claim under ATPD please provide the following:	
Nature of disability	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary
Name of the hospital where the insured was admitted	_____
Date of admission:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (Indoor patient No.: _____)
Date of discharge	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date of disability	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date of accident	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Place of accident	_____
Name of the police station where the FIR has been lodged	_____ _____

Date of FIR	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> (Please attach the copy of FIR along with this form)
Progress	<input type="checkbox"/> Improved <input type="checkbox"/> Fully recovered <input type="checkbox"/> Unimproved
Is the Life Assured capable of performing any occupation or engaging in activities for remuneration or profits?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PREVIOUS HEALTH/ HABIT DETAILS OF LIFE ASSURED:

Nature of Illness / Habit	Please Select Yes/No		Duration (since when)	If Yes, Quantity Details
	Y	N		
Hypertension	Y	N		
Diabetes	Y	N		
Heart disease	Y	N		
Kidney disease	Y	N		
Liver disease	Y	N		
Cancer	Y	N		
Any other ailments / disorder/ surgery/ hospitalisation in last 5 yrs	Y	N		
Any habits like smoking/ alcohol/ tobacco/ drugs (Please select)	Y	N		

Payment Details

Details of hospitalisation expenses and mode of payment				
Details of amount claimed under Medclaim/health insurance policy during last five years	Name of the Insurer	Sum Assured	Amount of claim received	Date of claim

Other details of the Life Assured:

Employment details

Last Employer's / Business name:	_____
Address	_____ _____ _____
Designation at work place/business:	_____
Last working date:	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Annual income	_____
Nature of Job/ Business	_____

Family Physician details

Name of the doctor	_____
Address & Tel. No.	_____ _____
Since when has been the Life Assured taking treatment from the doctor	_____
Name the illness for which treatment was taken	_____

Particulars of other Life Insurance / Mediclaim policies held by the Life Assured

Name of the Co./ TPA	Policy No.	Risk Commencement Date	Sum Assured	Claim Raised Yes/No	Status of Claim	Amount Claimed

Electronic Payout option (Direct transfer of funds in your bank a/c)

- Name of the Bank A/c holder: _____
 - Bank Name: _____ Branch Name: _____
 - A/c No.: _____
 - A/c Type: Saving Current NRI NRO
 - IFSC code: _____ MICR Code: _____
- Personalised cancelled cheque required along with this form

Payouts would be in accordance and subject to the terms and conditions of the policy. Further, the company reserves the right to use any alternative payout option including demand draft/payable at par cheque in spite of opting for Electronic payout method. I will not hold Edelweiss Tokio Life Insurance Company Ltd. responsible in case of non-credit to my bank account or if the transaction is delayed or not effected at all for reasons of incomplete/ incorrect information.

Date: Signature / Thumb impression of the claimant: _____

I, Mr. / Ms. / Mrs. _____ (name), _____ (relation) of Mr. / Ms. / Mrs. _____ (name of the Life Assured), do hereby declare and confirm that I am the rightful claimant of the deceased person and the above statements are true and complete in each & every respect.

In order to enable the company to assess the claim under this policy, I authorize the Company to procure documents/details from the

- past and present employer (s) business associates
- Medical practitioner/ Hospitals (Govt/ Pvt.)
- Any life and non life insurance company

And hereby give my consent to the above authorities to release to the company, such details/documents which may be required during the assessment of the claim.

In case where the Policy document is not submitted to the Company I, hereby agree to indemnify the Company against all liabilities that the Company may incur on account of any claim being made by any other person on the basis of possession of the Policy document or otherwise.

Yours Faithfully,

Signature / Thumb impression of the claimant	Name & signature of the witness
	Name: _____
	Signature: _____
	Relation with the claimant: _____
Telephone with STD code: _____	Telephone with STD code: _____
Place: _____	Place: _____
Date: _____	Date: _____