POLICY SERVICE REQUEST FORM

Edelweiss Tokio life

Edelweiss Tokio Life Insurance Company Limited | IRDAI Regn. No. : 147 | CIN: U66010MH2009PLC197336
Registered Office: 6th Floor, Tower 3, Wing 'B', Kohinoor City, Kirol Road, Kurla (W), Mumbai 400070

Policy No.: E GSTIN Date: D D M M Y Y Y Y

Name of the Policy Holder: _____ Tel. No.: _____

Address: _____

_____ Pin Code: _____

☐ Change in Name

☐ Life Assured ☐ Policy Holder

Change in Name From:
First Name Middle Name Last Name

Change in Name To:
First Name Middle Name Last Name

- Married woman whose name has been changed due to marriage is requested to submit the Marriage certificate along with this form.
- For all others, attested copies of Gazette notification are required to be submitted.

☐ Change in Correspondence Address

New Address:

City / District: State: Pin Code:

(Provide any of the following Address proofs along with this form)

☐ Electricity Bill* ☐ Telephone Bill* ☐ Passport ☐ Bank Statement* ☐ Ration Card ☐ Voter's Card ☐ Driving License

☐ Others _____ *[* Utility bills which are not more than two (2) months old of any service provider (Electricity, Telephone bill, etc.). Current passbook with details of permanent/present residence address (updated upto the previous month) or Current Bank account statement with details of permanent/present residence address as downloaded]*

☐ Change in Contact Details / Email ID

New Mobile No.: + - Landline No.: -
Country Code Mobile Number Area Code Tel. Number

New Alternate Contact No.: - PAN
Area Code Contact Number

Aadhaar Card No.

New Email ID:

☐ Updation of Bank Account Details

Bank Name

Branch Name Branch Address

Account Holder's Name

Account No. IFSC

MICR

- Note all policy payouts will be made to the above account
- Update the company in case there is any change in your bank account details.

Account Proof accepted: Cancelled Cheque / Bank Pass Book / Bank Statement

Signature of the Policy Holder

Addition of Rider

Total Premium	Choice of Rider (Sum Assured in ₹)							
	Critical Illness	Accidental Death Benefit	Accidental Total and Permanent Disability	Hospital Cash Benefit	Term	Payor Waiver Benefit*	Waiver of Premium	
							Y	N

* Payor Waiver Benefit Rider: ☐ On Death ☐ On CI or ATPD ☐ On Death, CI or ATPD
(Applicable only when Life Insured and Proposer are different)

Top-Up Premium

A. Fill the fund allocation of your Top-up premium

Name of the Fund	Amount (₹)
Equity Large Cap Fund (SFIN:ULIF00118/08/11EQLARGECAP147)	
Equity Top 250 Fund (SFIN:ULIF0027/07/11EQTOP250147)	
Bond Fund (SFIN:ULIF00317/08/11BONDFUND147)	
Money Market Fund (SFIN:ULIF00425/08/11MONEYMARKET147)	
Price Earning Based Fund (SFIN:ULIF00526/08/11PEBASED147)	
Managed Fund (SFIN:ULIF00618/08/11MANAGED147)	
TOTAL	

B. Top-Up Amount: ☐ Minimum ☐ Maximum

- Top-Up premium is subject to terms and conditions of the policy.
- It is mandatory to submit duly filled Certificate of Insurability & same will be subject to underwriting norms.
- Income Proof if the Top-Up amount is more than ₹ 100,000/-.

Change in Premium Payment Method / Billing Frequency

Premium payment Method: ☐ Direct Bill ☐ ECS ☐ CC Standing Instruction
(ECS Mandate & Cancelled cheque would be required if opted for ECS) (CCSI Form & Front Copy of Credit Card would be required, if opted for CCSI)

Billing Frequency Required: ☐ Annual ☐ Semi Annual ☐ Quarterly ☐ Monthly

Changes in Sum Assured

☐ Increase ☐ Decrease

From ₹ : ☐☐☐☐☐☐☐☐☐☐ Required ₹ : ☐☐☐☐☐☐☐☐☐☐

Note : Change in sum assured is subject to terms and condition of the policy or evidence of insurability in accordance with company under writing guidelines.

DECLARATION: Upon signing the request above, I, the Policy Holder hereby declare that all the information given above is true and correct and I agree to all the terms and conditions.

For Branch Office Use

Staff Name: _____

Staff Sign: _____

Date: _____ Time: _____ a.m./p.m.

Signature of the Policy Holder

Date: D D M M Y Y Y Y Place: _____

PSRF/Jun_2017/Ver 4.3

Acknowledgement Slip

Received a request for _____ for policy no.: _____ on D D M M Y Y Y Y at ____ a.m./p.m.

Corporate Office:
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Stamp/ Seal of the Branch