IndiaFirst
LIFE INSURANCE

Claim Intimation Form – Disability

Please attach this form after fully completing it with a copy of the death certificate to help us process your claim promptly.

Life assured's details

Name: **Policy number:**

Date of birth:

Address:

City and Pin code: **State:**

Occupation:

Claimant's details, if different from the life assured:

Name:

Date of birth:

City and Pin code: **State:**

Occupation:

Policy in possession of:

Assignment details

Is the policy assigned? **Yes** ☐ **No** ☐

If yes,

Name:

Address:

City and Pin code: **State:**

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A Joint Venture of
Bank of Baroda Legal & General Andhra Bank

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Accident details

Date and time of the accident:

Exact place of accident:

How did the accident occur?

People involved in this accident.
Name(s), address(es) and contact no.:

Name and address of the police station
where the FIR has been lodged:

Diability details

Body parts affected:

Date of disability:

Nature of disability:

Surgery details undergone by the life assured due to disability:

Date of admission in the hospital: **Date of discharge from the hospital:**

Date and time of surgery:

Exact name of the surgery:

Name and address of the hospital(s)
where the aurgery was performed or any consultation done:

Name and designation of the performing surgeon/ any other doctor consulted:

Contact details of the doctor/surgeon

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Employment details:

Prior to disability:
Name of the Company/ Business:

Exact nature of the job:

Post disability:

Is the life assured currently employed? Yes ☐ No ☐

If yes, then please provide the following details:
Name of the company/ business:

Exact nature of the job:

If not employed, then date from which the life assured stopped working:

Date by which the life assured is expected to return to work:

Other insurance details

Name of the company	Issue date	Sum assured

I hereby declare and confirm that I am the rightful claimant of this plan and that the details provided above are correct and true to the best of my knowledge. I have not withheld any relevant information and believe that the deceased is the same person as the life assured under the plan issued by IndiaFirst Life Insurance Company Ltd.

Through this statement, I authorize any hospital, institution, nursing home, medical clinic or medical practitioner who has treated or examined the deceased to provide IndiaFirst/ any court of law/ any grievance redressal forum with any medical information regarding the deceased's state of health which he/ she may have acquired before or after the issuance of the plan on its request. This authorisation is notwithstanding any law, custom or usage for the time being in force which prohibits any physician or hospital from divulging any knowledge or information, acquired by him/them in attending upon or examining a person on the ground of secrecy.

Further, I authorise any insurance company, government organization, employer, other organization, institution or person to release to IndiaFirst or its duly authorized representatives any record or knowledge about deceased. Such information shall without limitation include information about deceased's health (including any information relating to the use of drugs or alcohol, AIDS, or mental and physical history, condition, advice or treatment), earnings or other insurance benefits, including any accounting information of the life assured's account.

Lastly, I declare that I am entitled to make the above authorisations and agree to help IndiaFirst or its duly authorized representatives to gather any information and use it as may be deemed fit to help process this claim.

Date:

Claimant signature:

Claimant name:

Address:

City and Pin code: State:

Phone number: Mobile:

Claims process requirements

	Please tick
Mandatory documents (for all claims)	
Original plan document	
FIR/ Panchnama/ Inquest report	
Medical records (admission notes, discharge summary, test reports etc)	
Copy of driving license if the life assured was driving the vehicle at the time of the accident	