



jeevan suraksha ka
naya nazariya

Bharti AXA Life Insurance Company Limited
Unit No. 601 & 602, 6th floor, Raheja Titanium, Off Western Express Highway,
Goregaon (East), Mumbai - 400 063. www.bharti-axalife.com
Toll Free: 1800-102-4444

DISABILITY CLAIMANT'S STATEMENT

(To be completed by the Claimant)

No fees, commission or charges of whatever nature are payable to Agents or Employees of the Company in respect of this claim.

Policy No	Name of Life Insured	Name of Claimant	Current Residential Address & Contact No. of Claimant

Requirements to be submitted along with this form.

Accidental Disability / Death Rider Claim Requirements	Please Tick whichever documents you have submitted
1. Original Policy Kit	
2. Copies of Medical Records, Test Reports, Discharge summary, Admission records of hospitals and indoor case papers	
3. Disability Claimant's Statement.	
4. Copy of bank passbook / bank statement.	
5. Copy of Address Proof.	
6. Disability Attending Doctor's Certificate	
7. Hospital Treatment Certificate	
8. Treating Doctor's Certificate	
9. First Information Report	
10. Police Inquest Report	
11. Driving license of the life insured in case of disability due to road accident	

Note: The Company reserves the right to call for additional requirements, if needed

1. Information on the Disability

(a) Is the disability related to an accident? If yes, please provide details.

Nature of the Accident	Date & Time	Place	Description

(b) How long has the Life Insured been continuously disabled because of the above disability?

.....

 (c) Has the Life Insured previously suffered from or been treated for the above symptoms or disability?
 If yes, please provide details.

Date	Name of the Doctor / Hospital	Address

(d) Name & Address of Life Insured's Usual Doctor:

Name	Address

2. Employment Details of Life Insured:

Occupation & Nature of Duties prior to the above disability	
Name & Address of the Employer	
Date of Cessation of work as a result of this disability	

3. Is the Life Insured eligible for similar benefits with any other insurance company?

Name of Insurer	Policy No	Policy Issue Date	Benefit Amount

Declaration and Authorization:

I/We do hereby declare that all the statements and answers to all questions given by me above are to the best of my knowledge and belief, correct, complete and true.

I/We authorize any doctor / hospital / laboratory / institution / past and present employer(s)/business associates/any life and non-life insurance company/organization or the Life Insurance Association's medical register to provide any knowledge or information concerning the life insured's health, habits or employment to the Company.

Signature of Claimant	Date

Name of Witness	Signature of Witness

