bharti AXA

jeevan suraksha ka
naya nazariya

BAR CODE

Policy Number:

			–							

CRITICAL ILLNESS / HOSPITALIZATION / DISABILITY CLAIM FORM (BY CLAIMANT)

We understand that claim is important to you. In order for us to speed up the process, please (1) complete this form, (2) prepare the relevant documents listed on page x, and (3) submit the form to your agent or AXA office as soon as possible

Please do not sign on blank form and use the same signature as policy record. No fees, commission or charges of whatever nature are payable to Agents or Employees of the Company in respect of this claim.

Issuance of this form does not amount to admission of any claim/liability under the policy on the part of the insurers

1. Claimant Information

Full name of claimant (Last, First, Middle)

Date of birth (dd/mm/yyyy) /

2. Type of claimed benefit

☐ Critical Illness	☐ Hospitalization	☐ Disability	☐ Other

3. About Current claim

Name and address of clinic or hospital attended for current claim

Most recent consultation date

Name and address of your family doctor or your usual attending doctor

Diagnosis / Reasons for current claim

4. If this claim is for Critical Illness benefit, please complete this section

Name of the Critical Illness

Date of diagnosis

5. If this claim requires hospitalization benefit, please complete this section

Date of admission		Date of discharge	
Doctor's diagnosis			

Please indicate if this is the first time you consult hospital for this diagnosis or the related signs and symptoms □ Yes □ No

6. Electronic Payout Mandate

- As per the regulatory notification, insurers are required to make all payouts through electronic mode only. Hence, amount would be credited to your below mentioned bank account details through NEFT / RTGS.
- Submit a personalized cancelled cheque along with this form to process the payment

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Payment Mode: ☐ NEFT ☐ ECS	MICR Code* (Mandatory for ECS):
Bank Name:	IFSC Code (Mandatory for NEFT):
	Account Type: ☐ Saving Account ☐ Current Account
Bank Address (Including State, City, Pin code):	Telephone with STD code:
	E- mail:

* 9 digit MICR code of the bank and branch appearing on the cheque issued by the bank.

Disclaimer:

- I understand that any payout under this Policy shall be strictly in accordance with the policy terms and conditions.
- I understand that submission of this document does not mean acceptance of claim
- I hereby declare that the particulars given in this form are true, correct and complete in all aspects.
- I take full responsibility of the genuineness and correctness of the details filled herein.
- If the transaction is delayed or not effected at all for any reasons due to incomplete or incorrect information, I shall not hold the Company responsible in any manner whatsoever.
- Further, I understand that the Company shall not be held responsible for any receipt of payment on account of wrong/ incorrect/incomplete information given by me in this form.
- I also understand and agree that the Company reserves the right to use any alternative payout option.

Bank Account No.:

Please put a tick in the box below to indicate the identity of the bank account holder in the policy

☐ Insured or covered person ☐ Policy owner ☐ Trustee ☐ Assignee (absolute assignment

I hereby take the sole responsibility for the correctness of my Bank Account number and other details of this form. I undertake that I will not hold the company responsible in any manner for any transactions affected by the company due to incorrect Bank Account No. Or these details stated by me.

7. Declaration & Authorization

Declaration and Authorization:

- I/We, Mr/Mrs/Ms ..... do hereby declare that all the statements and answers to all questions given by me above are best to my knowledge and belief, correct, complete and true.
- I /We, Mr/Mrs/Ms ..... authorize any doctor/hospital/laboratory/institution/past and present employer/business associates/any life & 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 including information relating to HIV (AIDS Virus), habits or employment to the Company.
- I/we agree that the Company may provide/transfer/retain any information available with the Company related to life insured/me/us, obtained in connection with processing of proposal/claim to any reinsurers, insurance association, medical registrar, statutory authorities/bodies or services providers engaged by the Company for policy servicing / claim related activities without any further reference to me/us;
- I/we agree that the Company may share life insured's/my/our information with other insurers for the claims settlement purposes;
- I/we understand that i/we have an option to review and correct the information already provided or not to provide the data or information sought, also, at any time while availing the services or otherwise, i/we have an option to withdraw my/our consent for sharing of data given earlier, such withdrawal of the consent should be sent in writing to the Company. In the case i/we do not provide or later on withdraw my/our consent, the Company shall have the option not to provide me/us the services.
- I/We do not agree with the use my/our personal data for direct marketing purposes and do not wish to receive any promotional and direct marketing materials.

Signature of claimant

Signature date

E-mail address

Contact phone number

☐ I agree the email address and contact phone number will be updated in this policy record

8. Document Requirements

Please tick against the documents you have submitted together with this claim form. If the mandatory documents are not available, your claim process may be processed only after the documents are received.

Mandatory documents for Critical Illness benefit	Mandatory documents for Hospitalization benefit
☐ Original Policy Bond ☐ Claim Form ☐ Personalized cancelled cheque ☐ Treating Doctor's certificate ☐ Medical Records like Discharge summary, Indoor case sheets, Final Hospital Bill, Test reports	☐ Copy of Policy Bond ☐ Claim Form ☐ Personalized cancelled cheque ☐ Treating Doctor's certificate ☐ Medical Records like Discharge summary, Indoor case sheets, Final Hospital Bill, Test reports

9. Online Claim Service

Make use of our following online claim services by visiting customer portal or www.bharti-axalife.com/claims:

- Online submission of claim and facility to upload the documents
- Track the status of your claim
- Submit feedback on your experience

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