



Policy No

Claim No.

Tata AIA Life Insurance Company Limited
(hereinafter called "Tata AIA" or "the Company", whichever is applicable)

APPLICATION FORM FOR CRITICAL ILLNESS (CLAIMANT'S STATEMENT)

Office _____
Agency _____ Code _____
Agent _____ Code _____

To be completed by the Life Insured or Claimant in BLOCK letters.

Please answer all questions, use "not applicable" (N/A) as appropriate instead of leaving it blank. Counter-sign where amendments/alterations are made in the form.

The filing of this claim form is not to be construed as an admission of liabilities of our Company. No agent is authorized to admit any liabilities on behalf of the Company.

| | |
|------------------------------------|--|
| Critical Illness Type claiming for | This is a <input type="checkbox"/> New Claim <input type="checkbox"/> Further Claim |
|------------------------------------|--|

Information of Insured

| | | |
|--|--|----------------------------------|
| Policy No. | Full Name of Insured Alias, if any | Age Sex |
| Are you the Payor of a Tata AIA Juvenile Policy? <input type="checkbox"/> Yes <input type="checkbox"/> No Juvenile Policy No. | Insured's Address Contact Phone No. | I. D. No. I. D. Document Type |
| Occupation | Employer Name & Address Contact Phone No. | |

Claim Details

| | |
|--|--|
| Describe initial symptoms | Date symptoms commenced MM DD YYYY |
| | Date of first consultation MM DD YYYY |
| Diagnosis given by doctor | The first doctor consulted (name, address & telephone) |
| Is the condition due to an accident? <input type="checkbox"/> No. <input type="checkbox"/> Yes, details are: | |
| Accident Date MM DD YYYY | Time (am / pm) Place |
| Accident Details | |

Consultation Details

| | Name, Address & Telephone | Attendance Date | Disease / Condition |
|---|---------------------------|-----------------|---------------------|
| a) Your regular doctor | | | |
| b) All other doctors consulted for this illness or related conditions | | | |

Registered and Corporate Office : Tata AIA Life Insurance Company Ltd. (IRDA Regn. No. 110), 14th Floor, Tower A, Peninsula Business Park, Senapati Bapat Marg, Lower Parel, Mumbai 400013. CIN: U66010MH2000PLC128403.

| | | | |
|--|--|--|--|
| Hospitals admitted & Doctor who referred Insured to hospital | | | |
|--|--|--|--|

| | | |
|---|-------------------|----------------|
| Have any of your blood relatives suffered from a similar or related illness/condition? <input type="checkbox"/> No <input type="checkbox"/> Yes, details: | | |
| Relationship of relative | Nature of illness | Date diagnosed |
| | | |

| | | |
|---|-------|--|
| Please give details any other illness you have suffered from in the past? | | |
| Disease/Condition | Dates | Doctor consulted (Name, Address & Telephone No.) |
| | | |

| | | | |
|---|------------|--|----------------|
| Life insurance amount covered by other companies: | | | |
| Name of Company | Policy No. | Effective Date or Coverage Commencement Date | Amount Insured |
| | | | |

Details of Claimant (if other than the Life Insured)

| | | | |
|--|-------------------------------|---------|-----|
| Name in Full | ID No. | ID Type | Age |
| Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> | Address | | |
| Telephone No | Relationship with the Insured | | |
| In what title are you submitting this claim? | | | |

Declaration & Authorization

I hereby declare that the information given on this critical illness claim application form is true and complete to the best of my knowledge and belief.

I hereby make claim to Tata AIA by submitting this critical illness claim application form and agree that the written statements of all the physicians who attended or treated the Insured and all other proofs and supporting documents associated with this critical illness claim application form shall constitute and are hereby made part of this critical illness claim application form. I further agree that the furnishing of this critical illness claim application form, or of any other forms supplemental hereto by the Company, shall not be deemed an acceptance of an existence of any assurance in force on the life in question, nor a waiver of any of its rights of defenses.

I hereby irrevocably authorize any organization, institution, or individual that has any record or knowledge of the Insured's health and medical history or any treatment or advice and that has been or may hereafter be consulted, other personal information or details of related accident/injury to disclose to Tata AIA such information. This authorization shall bind my successors and assigns and remain valid notwithstanding my death or incapacity in so far as legally possible. A photocopy of this authorization shall be as valid as the original.

I/We hereby declare and agree that any personal information collected or held by the Company (whether contained in this application or otherwise obtained) is provided and may be held, used, and disclosed by the Company to individuals/organizations associated with the Company or any selected third party (within or outside of India, including reinsurance and claims investigation companies and industry associations/federations) for the purposes of processing this application and providing subsequent services for this and other financial products and services, direct marketing, and data matching, and to communicate with me/us for such purposes.

Witness Signature : _____

Life Insured Signature : _____

Date : _____

Date : _____

Name of Witness : _____
(in block letters, family name first)

Policyowner/Claimant
Signature : _____
(if other than life insured) (in block letters, family name first)

Date : _____

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