CRITICAL ILLNESS CLAIM FORM

Pramerica LIFE INSURANCE

The Claims Department,
Pramerica Life Insurance Limited.

Please read the instructions mentioned on the last page before filling up this form.

Document's checklist /

1. All past and current medical/hospital records - admission notes, test records, discharge summary etc. (where applicable)
2. Original Policy Bond _____

In connection with Claim under Policy No. _____ for ₹ _____

on the life of _____ I, _____ the claimant

under the Policy make the following statement:

Particulars of the Life Insured /

Policy No(s):

Name of the Life Insured:

Title: Mr/Mrs/Ms/Dr. First Name Middle Name Surname

Date of Birth: D D M M Y Y Y Y

Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Single

Residential Address:

STD Code Landline Number Mobile Number Pin Code:

E-mail:

Name of Employer:

Employer contact details:

Address:

STD Code Landline Number Mobile Number Pin Code:

ELECTRONIC PAYOUT OPTION (Direct transfer of funds to your bank account). Please submit original cancelled cheque along with this form. (Account holder's name should be printed on the cheque leaf).

Name of Nominee/Claimant:

Bank & Branch Name:

Account No.: IFSC Code:

MICR Code:

Declaration: I/We authorize Pramerica Life Insurance Limited to process the proceeds under the Critical Illness of the aforesaid policy/s through Electronic Funds Transfer to the above mentioned bank account details. Further the Company reserves the right to use any alternative payout option including demand draft/ payable at par cheque irrespective of opting for Electronic Payout method. I/We, accept the full responsibility for above mentioned Bank account details. I/We will not hold Pramerica Life Insurance Limited liable for any loss if funds are transferred or not transferred or delayed due incomplete or incorrect or third party banking details provided above.

_____

Signature/Thumb impression of Life Insured/Claimant

Policy No. | | | | | | | | | | |

Details of critical illness /

Nature of critical illness/diagnosis: _____

First complaint of symptoms: _____

Date of first diagnosis: _____

How long has the Life Insured been under treatment? _____

Details of consultations /

Consultation	Name(s) of Doctor/Hospital	Address of Doctor/Hospital	Contact No of Doctor/Hospital	Date	Disease/ Condition
a) The first doctor consulted for this illness					
b) The doctor who referred the life Insured to hostipal for treatment					
c) All other doctors/ hospitals consulted for this/other illness					
d) Usual medical attendant family doctor					

Any other relevant information:

_____

_____

Authorisation

I/We _____ hereby authorise and give my/our consent to Pramerica Life Insurance Limited and/or its representatives to seek information, obtain all information, records in relation to employment, medical, hospital records, police records, other records (including photocopies) in connection with any treatment, occupation, personal details in connection with this claim.

_____

Signature of the Life Insured

Declaration

I/We hereby declare that the statements made herein above are true and correct. I/We further declare the written statement of all the physicians, and all papers furnished in support of this claim shall constitute proofs of critical illness. I/We further declare and agree that the furnishing of this form or any other forms supplemental thereto or any acts of enquiry or investigation by Pramerica Life Insurance Limited shall not constitute or be considered as an admission of the claim by the Company.

_____

Signature of the Life Insured

Name, Designation and Address of the Life Insured

_____

_____

_____

Policy No. | | | | | | | | | | |

Declaration (In case this form is filled by a person other than the Policy holder or signed in vernacular)

I hereby declare that the contents in this form have been fully explained to me and that whatever is stated herein above has been recorded as per the information provided by me.

_____

Thumb Impression/Signature of the Policy holder/Trustee on Date: D D M M Y Y Y Y

_____

Signature of the Assignee
(In case of Absolute Assignment of policy) on Date: D D M M Y Y Y Y

I hereby declare that I have explained the contents of this form to the Policy holder in_____ language and I have correctly recorded the information provided to me and I further declare that the Policy holder has signed/affixed his/her thumb impression in my presence.

_____

Signature of the Declarant filling the form

Name and Address of Declarant: (Please leave a space between each part of the name)

Title: Mr/Mrs/Ms/Dr. First Name Middle Name Surname

Address:

City: _____ State: _____ Pin Code:

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

Instructions

- All fields are mandatory
- All payments shall be subject to the terms and conditions of the Policy
- Pramerica Life Insurance Limited retains the right to call for additional evidence to process the claim
- The Company reserves the right to entertain or to repudiate the claim
- All alterations/corrections made, need to be counter signed by the Life Insured
- All copies of evidence must be attested by any of the following: A Notary Public, Block Development Officer, Magistrate, Commissioner of Oaths, Class 1 Gazetted Officer, Head Postmaster, Head master of a High School
- Each page of this form must be counter signed by any of the following: Advocate, Bank Manager, Block Development Officer, commissioner of Oaths, Gazetted Officer, President of Village Panchayat, Magistrate, Head master of a High School

Pramerica Life Insurance Limited
Registered Office and Communication Address: 7th & 8th Floor, Tower 2, Capital Business Park, Sector 48, Gurugram - 122018, Haryana. CIN: U66000HR2007PLC052028.

Contact Us: Customer Service Helpline: 1860 500 7070 (Local charges apply) or 011 4818 7070
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CIC/F-ENG/DEC/25/V6