IndusInd Nippon Life

Claim Form - Cancer Protection Plus

Policy No

Date D D M M Y Y Y Y

(A) DETAILS OF LIFE INSURED / PERSON DIAGNOSED WITH CANCER

Full Name FIRST MIDDLE LAST

Gender ☐ Male ☐ Female Age Date of Birth

Address FLAT NO.

BUILDING ROAD NAME / NO.

LANDMARK 1

DISTRICT / TALUK LANDMARK 2

CITY / VILLAGE STATE Pin Code

STD ISD Code LANDLINE MOBILE EMAIL ADDRESS

Occupation Nature of Work

Employer Name & Address FLAT NO.

BUILDING ROAD NAME / NO.

LANDMARK 1

DISTRICT / TALUK LANDMARK 2

CITY / VILLAGE STATE Pin Code

STD ISD Code LANDLINE MOBILE EMAIL ADDRESS

(B) DETAILS OF CLAIMANT

Name FIRST MIDDLE LAST

Gender ☐ Male ☐ Female Age Date of Birth Relationship to Life Insured (if other)

Address FLAT NO.

BUILDING ROAD NAME / NO.

LANDMARK 1

DISTRICT / TALUK LANDMARK 2

CITY / VILLAGE STATE Pin Code

STD ISD Code LANDLINE MOBILE EMAIL ADDRESS

(C) DETAILS OF CLAIM

Name of the Hospital where admitted / diagnosed

Reason for hospitalisation

Date of Admission Time

Date of Discharge Time

If Medico Legal ☐ Yes ☐ No

Reported to Police ☐ Yes ☐ No If yes Date Time

Medico Legal Certificate ☐ Yes ☐ No FIR attached ☐ Yes ☐ No

Type of Cancer ☐ Carcinoma in situ ☐ Early Stage Cancer ☐ Major Stage Cancer

Final Diagnosis ☐ Yes ☐ No

Date of Diagnosis Date of first consultation with Doctor

Nature and duration of complaints necessitating medical attention

Date when these complaints first became evident Site of Tumor

Date of Death (where applicable)

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(D) PAST HEALTH HISTORY OF LIFE INSURED

1. Any other illness / Surgery prior to the current illness:

Date when this illness was first detected:

2. Any Previous Malignancy (Cancerous) or Pre Malignancy conditions ☐ Yes ☐ No

If yes, provide details in the table below:

Sr.No.	Name of Hospital / Doctor	Contact Details of Hospital / Doctor	Date of Admission & Discharge / Consultation	Diagnosis
1.				
2.				
3.				
4.				
5.				

(NOTE - If the space provided for any of the above is inadequate,please attach annexures)

(E) DETAILS OF HABITS OF LIFE INSURED

Description	Details	Quantity Per Day	Duration
Tobacco	☐ Cigarettes ☐ Bidis ☐ Chewing Tobacco ☐ Any other _____		
Alcohol	☐ Beer ☐ Whisky ☐ Wine ☐ Any other _____		
Drugs			
Any other			

(NOTE - If the space provided for any of the above is inadequate,please attach annexures)

(F) DETAILS OF MEDICAL / SICK LEAVES TAKEN BY THE LIFE INSURED IN LAST 5 YEARS

Dates From	Dates To	Reasons for the Leave as per Application/Medical Certificate	Name & Contact No. of Treating Doctor

(G) DETAILS OF OTHER INSURANCE OF LIFE INSURED (including Health & Mediclaim Policies):

Policy No	Company Name	Sum Assured	Commencement Date	Current Policy Status

(NOTE - If the space provided for any of the above is inadequate,please attach annexures)

(H) BANK ACCOUNT DETAILS OF LIFE INSURED / CLAIMANT

Name as per Bank Records F I R S T M I D D L E L A S T

Bank Name

Branch Name

Account Number

IFSC Code

PAN Number

Self-attested photocopy to be attached of a) Personalized cancelled Cheque or b) Completed Bank Authorization Form, attested by the Bank; along with self-attested copy of Passbook / Bank Statement with IFSC and Bank Account number mentioned thereon

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(I) DECLARATION CUM AUTHORIZATION BY THE LIFE INSURED/CLAIMANT

I hereby declare that the statements made in this claim form by me are true and correct to the best of my knowledge and belief. I also hereby authorize and direct any doctor, hospital, employer, police or any other related authorities to provide to IndusInd Nippon Life Insurance any information relating to the Life s health or employment or any other related matters for considering the claim.

Signature of the Witness

Signature of Claimant

(To be filled up by the relative of Life Insured other than the Nominee)

Date D D M M Y Y Y Y

Witness Name FIRST MIDDLE LAST

Address FLAT NO. BUILDING ROAD NAME / NO. LANDMARK 1 DISTRICT / TALUKA LANDMARK 2 CITY / VILLAGE STATE Pin Code

STD ISD Code LANDLINE MOBILE EMAIL ADDRESS

Important Note: Please ensure to send all Claim Forms and documents to Claims Department, Mumbai at IndusInd Nippon Life Insurance, Office No. 701 & 702, 7th Floor, Silver Metropolis, Off Western Express Highway, Goregaon East, Mumbai - 400063. India.

(J) Declaration by the person completing this claim form

IndusInd Nippon Life Insurance requires that this form is completed by the Claimant. If this is not possible because the claimant does not read, write or speak English, then this form may be completed by another person who must complete the following declaration.

I have explained the contents of this form to the claimant and endeavored to ensure that the contents have been fully understood. I have accurately recorded the responses to the information sought by this Claim form and I have read the responses back to the claimant and confirmed that they are correct.

Declarant Name FIRST MIDDLE LAST

Address FLAT NO. BUILDING ROAD NAME / NO. LANDMARK 1 DISTRICT / TALUKA LANDMARK 2 CITY / VILLAGE STATE Pin Code

STD ISD Code LANDLINE MOBILE EMAIL ADDRESS

Date D D M M Y Y Y Y

Signature of Declarant

For Internal Use: To be filled by the Branch CCE	
Claimant Name/Relationship	
Claimant contact no.	
Name of the Branch CCE	
SAP code of the CCE	
Contact no. of the CCE	
E-mail ID of the CCE	
Claim form received date at branch	
Signature of the CCE	

CIN: U66010MH2001PLC167089

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