



Claim Form A - Critical Illness

Date

Name of the Life Assured F I R S T M I D D L E L A S T

Correspondence Address/ Usual place of residence																	F	L	A	T		N	O.
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	B	U	I	L	D	I	N	G						R	O	A	D		N	A	M	E	/	N	O.				
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[illegible]

DISTRICT / TAILUKA LANDMARK?

CITY / VILLAGE _____ STATE _____ Zip Code _____

[illegible][illegible]

Mention full particulars of all other policies held by the Life Assured with other Companies.

	Policy Number	Date of Commencement	Sum Assured
1.			
2.			
3.			
4.			
5.			

NOTE - If the space provided for the above is inadequate, please attach annexures

Date of diagnosis/illness DDMMYYYY Date of Admission DDMMYYYY Date of Discharge DDMMYYYY

Details of diagnosis	
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When did you first complain of illness? (Date/Month)

What was the nature of complaint?

Name, address and telephone number of the Doctor who diagnosed/treated your illness initially

Address

BUILDING ROAD NAME / NO

[illegible][illegible][illegible]

SID code	L	A	N	D	E	T	E				M	O	B	I	L	E				EMAIL ADDRESS
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Name, address of the Hospital

[illegible]

BUILDING ROAD NAME / NO

[illegible][illegible][illegible][illegible]

STD ISO Code	L	A	N	D	L	I	N	E				M	O	B	I	L	E				EMAIL ADDRESS
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Bank Account Details of Life assured (Please note that all the payments would be made only through direct transfer to the Bank Account, hence cancelled cheque leaf is to be attached).

Bank Details ADDRESS

[illegible]

		R	A	N	K		N	A	M	E						P	B	R	A	N	C	H		N	A	M	E				
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[illegible]

☐ Policy document
 ☐ Original reports including all investigation reports
 ☐ Doctor/hospital certificate/s
 ☐ Cancelled cheque & bank passbook/bank statement
 ☐ Other

Signature of the Witness										Signature of the Life Assured																																														
																																				Date	D	D	M	M	Y	Y	Y	Y												
Name of the Witness		F	I	R	S	T							M	I	D	D	L	E									L	A	S	T																										
Address		F	I	R	S	T												L	A	S	T				F	L	A	T		N	O.																									
	B	U	I	L	D	I	N	G									R	O	A	D		N	A	M	E	/	N	O.																												
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	C	I	T	Y	/	V	I	L	L	A	G	E						S	T	A	T	E																																		
STD ISD Code	L	A	N	D	L	I	N	E					M	O	B	I	L	E					Pin Code																	EMAIL ADDRESS																

Name of Declarant						F	I	R	S	T					M	I	D	D	L	E									L	A	S	T					
Address of Declarant																													F	L	A	T		N	O.		
	B	U	I	L	D	I	N	G									R	O	A	D		N	A	M	E	/	N	O.									
																	L	A	N	D	M	A	R	K	1												
	D	I	S	T	R	I	C	T	/	T	A	L	U	K	A				L	A	N	D	M	A	R	K	2										
	C	I	T	Y	/	V	I	L	L	A	G	E						S	T	A	T	E															
STD ISD Code		L	A	N	D	L	I	N	E					M	O	B	I	L	E					EMAIL ADDRESS													

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	

IndusInd Nippon Life Insurance Company Limited (Formerly Reliance Nippon Life Insurance Company Limited). IRDAI Registration No. 121. Registered & Corporate Office: Unit Nos. 401B, 402, 403 & 404, 4th Floor, Inspire-BKC, G Block, BKC Main Road, Bandra Kurla Complex, Bandra East, Mumbai-400051, India. T +91 22 6896 5000. For more information or any grievance, 1. Call us between 8 am to 8 pm, Monday to Saturday (except public holidays) on our Toll-Free Number - 1800 102 1010 or 2. Visit us at www.indusindnipponlife.com 3. Email us at customerservice@indusindnipponlife.com 4. Chat with us on our WhatsApp number (+91) 7208852700. The trade logo displayed above belongs to IndusInd International Holdings Limited & Nippon Life Insurance Company and is used by IndusInd Nippon Life Insurance Company Limited under license.

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