| Policy No.: |
|---|
| Claim No.: |

# Tata AIA Life Insurance Company Limited

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

## TOTAL & PERMANENT DISABILITY CLAIM FORM

Office _____
Agency _____ Code _____
Agent _____ Code _____

**PART 1 (TO BE COMPLETED BY INSURED/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 has been or is authorized to admit any liabilities on behalf of the Company.**

| Policy No.: | Name of Insured:<br>I/D No: | Age:<br>Sex: | This is a ☐ New Claim<br>☐ Further Claim |
|---|---|---|---|
| Mailing Address: | | Contact Phone No.: | |

EMPLOYMENT PARTICULARS:

| | |
|---|---|
| 1. Occupation (if more than one, state all) and exact nature of occupational duties before disability | 1. |
| 2. Name and address of business or employer | 2. |
| 3. Did you file a sick leave certificate with your employer? | 3. ☐ Yes ☐ No |
| 4. Date your last worked: | 4. _____ DD _____ MM _____ YYYY |
| 5. Date you returned to work. (If no, then give expected date of return) | 4. _____ DD _____ MM _____ YYYY |

PLEASE COMPLETE IF DISABILITY WAS DUE TO ACCIDENT:

| | |
|---|---|
| 6a. Date , time and location of accident: | 6a. _____ DD _____ MM _____ YYYY _____am/pm<br>at _____ city |
| b. Where and how did it happen? | 6b. |
| c. Part of body injured and type of injury. | 6c |

PLEASE COMPLETE IF DISABILITY WAS DUE TO ILLNESS:

| | |
|---|---|
| 7a. Indicate the illness and give a brief description of symptoms. | 7a. |
| b. How long had he/she been having these symptoms | 7b. |
| c. Give details of consultation.<br>i) The doctor first consulted for this illness.<br>ii) The doctor who referred the insured to hospital.<br>iii) Doctors seen for any similar condition in the past. | 7c. Date Name(s) and Address(es) of Doctor(s)/Hospital(s)<br>i)<br>ii)<br>iii) |

8. DETAILS OF PHYCICIAN(S) CONSULTED OR HOSPITAL(S) ADMITTED FOR CURRENT DISABILITY

| | Name(s) | Address(es) | Admission/Patient No. (s) | Admission Date(s) |
|---|---|---|---|---|
| a) | | | | |
| b) | | | | |
| c) | | | | |

9. ARE YOU CURRENTLY INSURED FOR DISABILITY BENEFIT WITH ANY OTHER INSURANCE COMPANY OR INSTITUTION
(If "YES", please provide following information)

| | Name of Insurer Company/Institution | Amount of Life Insurance | Rider Attached | Policy Number |
|---|---|---|---|---|
| a) | | | | |
| b) | | | | |
| c) | | | | |

DECLARATION AND AUTHORIZATION

I declare that the answers given are true and complete.

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. I/We understand that the Company may be unable to process this application if I/We fail to provide any information requested in this application.

I hereby irrevocably authorize:

a. any organization, institution, or individual that has any record or knowledge of my/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 the Company such information. This authorization shall bind my/the Insured's successors and assigns and remain valid notwithstanding my/the Insured's heath or incapacity in so far as legally possible. A photocopy of this authorization shall be as valid as the original.

b. the Company or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests to underwrite and evaluate my/the Insured's health status in relation to this application and any claim arising therefrom. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, acquired immunodeficiency syndrome (AIDS), infection by any human immunodeficiency virus (HIV), immune disorder or the presence of medications, drugs, nicotine or their metabolites.

_____ _____

Witness Signature of Insured (see Remark)

Date :

Remark: This declaration and authorization must be signed by the Insured. If the Insured is a minor, the Insured's parent/legal guardian can sign on his/her behalf.

Please complete if the signature is not given by the Insured.

Name (in block letter) _____Relationship with Insured :_____