



DETAILS OF CLAIM FOR DISMEMBERMENT / TOTAL PERMANENT DISABILITY RIDER BENEFIT

Policy No. _____

Client Id. _____

Intimation by: _____

Contact No. : _____

Relationship with the insured: _____

Details of Loss:

1. Name of the Insured : _____

2. Date of Accident : _____

3. Details of Accident : _____

4. What were the initial symptoms?

5. Which doctor(s) were summoned? (Provide us with the name & contact details)

6. What was the diagnosis :

7. What treatment was given? _____

8. Was any operation performed? _____

9. Details about hospitalization :

Name of the Hospital	
Address	
Contact Nos	
Date of Admission	
Date of Illness/Loss	
Name of Attending Doctor	



10. Was he treated in the same hospital or any other hospital in the past?

11. Were there any related/unrelated illnesses in the past? And where was he treated?

Signature: _____

Name of Branch Manager/Executive: _____

Branch: _____

Date: _____

Incase, Intimation is through direct walk - in at HO/Zone/Branch :

Signature of the person intimatin _____