PNB MetLife India Insurance Company Limited
Registered office: Unit No. 701, 702 & 703, 7th Floor, West Wing, Raheja Towers, 26/27 M G Road, Bangalore -560001, Karnataka. IRDA of India Registration number 117.
CI No. U66010KA2001PLC028883, Call us Toll-free at 1-800-425-6969, Website: www.pnbmetlife.com, Email: indiaservice@pnbmetlife.co.in or write to us at 1st Floor, Techniplex -1, Techniplex Complex, Off Veer Savarkar Flyover, Goregaon (West), Mumbai – 400062. Phone: +91-22-41790000, Fax: +91-22-41790203

Disability Claim Form

POLICY NUMBER													

Important Instructions:

To be completed by the 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.
Witness signature is mandatory. Witness should be a Gazetted Officer/Notary Public/Magistrate or Person of local standing. CLAIMANT SHOULD SIGN ON ALL PAGES AT BOTTOM
The filling 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.
Please submit the form & the requirements at the nearest branch office or the address mentioned above.
Early and complete submission of requirements would enable the company to process claims at the earliest.

CLAIMANT DETAILS:

Name of the Insured: _____

Address: _____

Contact No.: _____ E-mail address: _____

Bank Account Number of the Claimant*: _____
(favoring which the claim cheque is to be issued)

Name & Address of the Bank*: _____

DETAILS OF THE DOCTOR/HOSPITAL TREATED THE INSURED FOR DISABLITY:

Name of the Doctor: _____

Name of the Hospital: _____

Address: _____

Contact No.: _____ E-mail address: _____

SPECIFY WHICH DISABILITY IS APPLICABLE (List as per Policy Definitions)**:**

- ☐ Loss of sight of one Eye
- ☐ Loss on use of one Limb
- ☐ Loss of sight of both the eyes
- ☐ Loss of Hearing
- ☐ Loss of use of two limbs
- ☐ Loss of one limb & loss of sight of one eye
- ☐ Loss of speech and hearing
- ☐ Loss of Speech

DETAILS OF ACCIDENT:

Cause of Accident: _____

Date of Accident: _____

Is FIR lodged: ☐ Yes ☐ No

If "yes" please attach the copy of Accident: _____

HISTORY

Date of appearance of first symptoms: _____

Have you ever had the similar condition in past: ❒ Yes ❒ No

(If "yes," state when and provide details): _____

_____

PRESENT CONDITION:

Present symptoms: _____

Findings (include results of current X-rays, ECGs or any other special tests): _____

_____

TREATMENT:

Date of first visit to Hospital/Doctor in this regard: _____

OP Number/Hospital No/Indoor Patient No.: _____

Date of last visit: _____ Frequency of visits (Weekly/Monthly/Other): _____

Date of Last examination: _____

PROGRESS:

❒ Recovered ❒ Improved ❒ Unimproved ❒ Retrogressed

DECLARATION:

I do hereby declare that all the above statements are true and complete. I understand that in furnishing claim form **PNB MetLife** has not admitted liability or waived any of its rights. I hereby authorize the physician or hospital who has attended upon or examined or treated me for any ailment or illness to divulge any knowledge or information regarding my state of health which he/they may have acquired whether before or after the policy was issued by **PNB MetLife.**

Signature/Left Thumb impression of claimant: _____ Date: _____

Name & Signature of Witness: _____ Date: _____

Address of Witness: _____

Official Seal of the Witness:

Note: *Signature in Indian languages must have their English translation written beneath. Further the claimant signing in the Indian language should give a declaration in the Indian language that he has understood the contents of the above form fully and properly as explained to him in the Indian language by an English knowing person who shall also sign to the effect that he has fully explained the contents of the above form to claimant.*