Canara HSBC Life Insurance Co. Ltd.
139 P, Sector 44, Gurugram – 122003, Haryana (India)

Canara HSBC LIFE INSURANCE

Disability Claim Form D-C /

Important Information: /

1. **Claim settlement process doesn't require any payment of fee to anyone etc. In case anyone asks for it, then claimant must inform the Company at Toll free number 1800-180-0003,1800-103-0003**

2. The benefit is payable subject to the policy being in force on the date of event and also subject to the fulfillment of all terms and conditions / definitions as state in the policy

3. To be filled in by the Policyholder preferably

4. Submission of this form should not be construed as acceptance of the claim

5. Please submit this form and the requirements at the nearest branch or at the address as indicated below

Policy no(s): / _____ **1.**

Details of the Disabled: /

Name: / _____Age at Claim: / :_____Years: / _____

Residential Address: / _____ Pin: /

_____

2. Details of the Claimant if different from Disabled / Policyholder /

Name: / _____Relationship with Disabled: / Self /

Other: / _____ Nationality/ :_____Country of Residence/ :_____

Claiming as: / Nominee / Assignee / Other / _____

Contact Address: / _____Pin / _____

Telephone: _____ Mobile: / _____ E-mail ID:/ _____

PAN Number/ Form 60 _____

Please enclose a copy of self attested photo ID proof (Please tick whichever is submitted)

Passport / Driving License / Voter's ID card PAN card / Company ID card /

Other : / : **3. Details of person entitled to receive disability claim proceeds under the policy (MANDATORY):**

Bank Account No./ _____ Type of Account: Saving Current NRE NRO

(In case of NRI Claimant, please provide NRO account number only) /(NRI

IFS Code/ _____

Bank Name and Address/ _____

Note- Kindly attach a copy of **cancelled cheque** with account number and name of the account holder printed on it or Copy of self-attested **Bank Account Statement / Bank Passbook.**

4. Particulars of Accident: /

Date and Time of Accident:_____ Exact place of accident: _____

How did the accident occur? _____

Name & address of Police Station where FIR has been lodged:/

5. Particulars of illness: (which preceded the current condition of disability):/

Name of the illness / Diagnosis:_____

Initial symptoms were noted on: _____Date of Diagnosis: _____

Initial signs and symptoms: _____

Details of doctor who first diagnosed the illness;

6. Details of Disability: /

Please mention the activities that the Disabled is Not able to perform currently:/

☐ Hearing ☐ ☐ Speaking / Seeing /

☐ ☐ ☐

Moving around / Bathing / Dressing /

☐ ☐ ☐

☐ Walking / Commuting / Feeding himself /

Using the toilet /

Name the parts of the body affected;_____ Date of disability:_____

Nature of disability:_____

7. Treatment taken by Disabled due to Illness / Accident:/

Date of admission in the hospital: _____

Date of discharge from the hospital: _____

Date & time of Surgery: _____

Name of surgery: _____

Name & Address of the hospital(s) where the Treatment was taken: _____

_____

Pin code: _____ Tel No._____

Name, Designation & Qualification of the Physician / surgeon: _____

Tel No._____

8. Details of follow up treatment till date:/

Dates of the treatment		Nature of the treatment	Name of the treating doctor	Hospital / Clinic Name, address & Telephone no.
From/	To/			

9. Employment Details:/

a. Prior to disability:/

Name of the Company / Business: _____

Designation of Disabled: _____ Exact nature of the job:_____

_____ **b.**

Post disability:/

Is the Disabled currently employed? ☐ Yes. ☐ No. If yes, then please give following details:

Name of the Company / Business: _____ Designation of Disabled: _____

Exact nature of the job: _____

Department: _____ Address: _____

_____

Pin code: _____ Tel No. _____ If not employed, then date from which the

Disabled stopped working:

Date by which the Disabled is expected to return to work: _____

_____

Has the disabled applied for any jobs ☐ Yes ☐ No

☐ ☐

If yes, please mention the nature of job applied

_____

_____

10. If the Disabled is currently undergoing any rehabilitation program, please give details such as name of the institute, duration and nature of program:

Name of the Institute	Duration	Nature of Program

11. Particulars of other Life Insurance / Mediclaim / Personal accident policies held by the Disabled:

Policy No. /	1	2	3
Name of the company /			
Commencement date /			
Sum Assured /			
Riders opted /			
Year of Claim /			
Cause of Claim /			
Amount of Claim /			
Status of the Claim /			

12. Declaration and Authorization: /

I/We do hereby declare that the information provided hereinabove is true in each and every respect and the settlement of claim shall strictly be in accordance with the policy terms and conditions. I irrevocably authorize all the medical establishments (medical labs included), government institutions/ agencies (police authorities, revenue, etc.) to reveal/share mental and physical treatment information

(past and present) including HIV/AIDS and others, related to the Life Assured, to Canara HSBC Life Insurance Co. Ltd ("Company") and/or its agents and authorized representatives. I authorize the Company to share and obtain information, including financial details, on my/our behalf with any reinsurer, insurance association, medical authorities, other insurers, statutory authorities, employer, court, governmental body, regulator, an investigation agency or other service provider(s) for settlement of claim, etc. without obtaining my specific consent for such sharing and I hereby provide my consent for the same. A photo copy of this declaration shall be considered as valid and effective.

Signature/left hand thumb impression of Claimants / Nominee

Name/ _____

Address/ _____

Date ☐☐/☐☐/☐☐☐☐

Name & signature of the witness

Name/ _____

Relation with claimant _____

Mobile number _____

Address/ _____

Date ☐☐/☐☐/☐☐☐☐

Declaration in case of an illiterate claimant/s should be made by a person who is unconnected to the company and whose identity can be easily established:

"I hereby declare that the contents of this form are explained by me in_____ language understood by the claimant and that he/she has/have affixed his/her thumb impression to this form after fully understanding the contents thereof "

Employment details from the list below_____

(This form must be witnessed by any one of the following: (1) An agent of the Company, (2) A Relationship Manager of the Company, (3) A Branch Manager of the distributing bank, (4) A Bank Manager of a Nationalized bank with Rubber Stamp, (5) A Gazetted Officer, (6) A Head Master / Principal of a Govt. School, (7) A Magistrate (8) Any employee of the Company.)

Requirements to be submitted along with this form*:/

Requirements/	**Please tick if Submitted**
1. Original Policy Bond /	☐
2. Photo ID & address proof of the claimant (duly attested) /	☐
3. Copy of self attested Bank Passbook/cancel cheque /	☐
4. Physician's Statement (Form D–P) /	☐
5. Treating Hospital Certificate (Form D–H) /	☐
6. Medical records from Hospitals & Doctors (Admission notes, progress sheets, Discharge summary, reports of diagnostic tests, medical prescriptions, etc) /	☐
7. Employer Certificate (Form D–E) /	☐
8. First Information Report (FIR) /	☐

9. Panchnama, Police Investigation Report /	☐
10. Newspaper Clippings, if available /	☐
11. Copy of Driving License if Disabled was driving at the time of accident (only in case of accidental disability claims)	☐

* Company reserves the right to call for any additional requirements.

* Processing of the requests will be initiated on receipt of this form at any of our Company's Offices.

Canara HSBC Life Insurance Company Limited (IRDARegn. No. 136)

139 P, Sector 44, Gurugram – 122003, Haryana (India) Regd Office : C-31 and C-32, First Floor, Connaught Circus, New Delhi - 110 001, Corporate Identification No.- U66010DL2007PLC248825, Contact 1800-180-0003, 1800-103-0003 (Tel)/ +91 0124 4535099 (Fax)/ Email : customerservice@canarahsbclife.in, Website : www.canarahsbclife.com