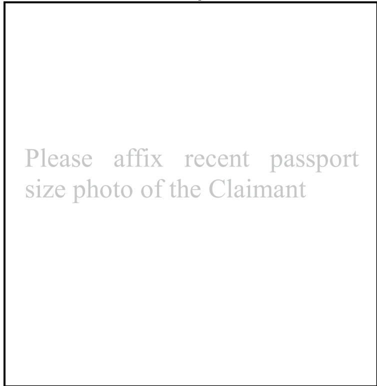
TATA AIA
LIFE INSURANCE

Policy No
Claim No.

Tata AIA Life Insurance Company Limited

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

APPLICATION FORM FOR CRITICAL ILLNESS (CLAIMANT’S STATEMENT)



Office ______________________________
Agency ____________ Code ____________
Agent ____________ Code ____________

To be completed by the Life Insured or 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 is authorized to admit any liabilities on behalf of the Company.

Critical Illness Type claiming for	This is a ☐ New Claim ☐ Further Claim

Information of Insured

Policy No.	Full Name of Insured Alias, if any	Date of Birth - D D M M Y Y Sex M F
Are you the Payor of a Tata AIA Juvenile Policy? ☐ Yes ☐ No Juvenile Policy No.	Insured’s Address Contact Phone No.	I. D. No. I. D. Document Type
Occupation	Employer Name & Address Contact Phone No.	
Pan Card No.		

Claim Details

Describe initial symptoms	Date symptoms commenced MM DD YYYY
	Date of first consultation MM DD YYYY
Diagnosis given by doctor	The first doctor consulted (name, address & telephone)

Is the condition due to an accident? ☐ No. ☐ Yes, details are:

Accident Date MM DD YYYY	Time (am / pm)	Place
Accident Details		

Consultation Details

	Name, Address & Telephone	Attendance Date	Disease / Condition
a) Your regular doctor			

Registered and Corporate Office : Tata AIA Life Insurance Company Ltd. (IRDA Reg. No. 110.CIN: U66010MH2000PLC128403),14th Floor, Tower A, Peninsula Business Park, Senapati Bapat Marg, Lower Parel, Mumbai 400013.
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Visit us at www.tataaia.com or call our helpline no.1860 266 9966 (local charges apply) or email us at customercare@tataaia.com or SMS “LIFE” to 58888
L&C/Misc/2017/Dec/474

b) All other doctors consulted for this illness or related conditions			
Hospitals admitted & Doctor who referred Insured to hospital			

Have any of your blood relatives suffered from a similar or related illness/condition? ☐ No ☐ Yes, details:

Relationship of relative	Nature of illness	Date diagnosed

Please give details any other illness you have suffered from in the past?

Disease/Condition	Dates	Doctor consulted (Name, Address & Telephone No.)

Life insurance amount covered by other companies:

Name of Company	Policy No.	Effective Date or Coverage Commencement Date	Amount Insured

Details of Claimant (if other than the Life Insured)

Name in Full	ID No.	ID Type	Age
Sex: Male ☐ Female ☐	Address		
Telephone No	Relationship with the Insured		
In what title are you submitting this claim?			

Declaration & Authorization

I hereby declare that the information given on this critical illness claim application form is true and complete to the best of my knowledge and belief.

I hereby make claim to Tata AIA by submitting this critical illness claim application form and agree that the written statements of all the physicians who attended or treated the Insured and all other proofs and supporting documents associated with this critical illness claim application form shall constitute and are hereby made part of this critical illness claim application form. I further agree that the furnishing of this critical illness claim application form, or of any other forms supplemental hereto by the Company, shall not be deemed an acceptance of an existence of any assurance in force on the life in question, nor a waiver of any of its rights of defenses.

I hereby irrevocably authorize any organization, institution, or individual that has any record or knowledge of 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 Tata AIA such information. This authorization shall bind my successors and assigns and remain valid notwithstanding my death or incapacity in so far as legally possible. A photocopy of this authorization shall be as valid as the original.

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.

Witness Signature : ______________________

Date : ______________________

Name of Witness : ______________________
(in block letters, family name first)

Life Insured Signature : ______________________

Date : ______________________

Policyowner/Claimant Signature : ______________________
(if other than life insured) (in block letters, family name first)

Date : ______________________