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

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

HOSPITALIZATION CLAIM FORM

Please affix recent passport size photo of the Claimant

Office _____
 Agency _____ Code _____
 Agent _____ Code _____

PART I (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.
 (Note: - Insured's name should be written in full as the same will appear on the cheque)

| | | | | | | | | | | |
|------------|---|---|---|---|---|---|---|---|---|---|
| Policy No. | Full Name of Insured Alias, if any | Date of Birth <table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td> </tr> </table> Sex <table border="1"> <tr> <td>M</td><td>F</td> </tr> </table> | D | D | M | M | Y | Y | M | F |
| D | D | M | M | Y | Y | | | | | |
| M | F | | | | | | | | | |

Benefits to Claim: (please tick)

Daily Hospital Benefit
 Post-Hospitalization Benefit
 Surgical Benefit
 Dismemberment

| | |
|--|--------------------------------------|
| Insured's Address Contact Phone No. | I. D. No. I. D. Document Type |
| Bank Account No. _____ | |

Pan Card No.

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|

| | |
|---------------------------|--|
| Occupation & exact duties | Employer Name & Address Contact Phone No. |
|---------------------------|--|

Are you claiming from other insurers or institutions (including government/welfare schemes) for the same cause?

Yes, for (type & amount) _____ from _____ No
 _____ from _____

Did a medical leave certificate filed to Insured's employer?
 Yes, (state the dates) _____
 No

Claims Details

| | |
|--|---|
| Describe initial symptoms / parts of body injured | Since when does the Insured have these symptoms / bodily injury 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? <input type="checkbox"/> No. <input type="checkbox"/> Yes, details below: | |
| Accident Date MM DD YYYY | Time (am / pm) Place |
| Accident Details | |

Consultation Details

| | Name, Address & Telephone | Consultation Dates | Disease / Condition |
|--|---------------------------|--|---------------------|
| a) Insured's regular doctor | | | |
| b) All other doctors consulted for this illness/injury; or similar condition in the past | | | |
| c) Doctor who referred Insured to hospital | | | |
| Please give details of any other illness Insured have suffered from in the past. | | | |
| Disease/Condition | Consultation Dates | Doctor consulted (Name, Address & Telephone No.) | |
| | | | |

Hospitalization Details

| Details of hospital confinement for the injury/illness. | | | | |
|--|---------|-------------------------|--------------------------|--------------------------|
| Name of Hospital | Address | Date of consultation(s) | Date & time of admission | Date & time of discharge |
| | | | | |
| Any surgical procedure(s) done during hospitalization? | | | | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes, details: | | | | |

Information of Claimant (if other than the Life Insured)**[Note:- Claimant name should be written in full as the same will appear on the cheque]**

| | | | |
|--|---------------------------------------|---------|-----|
| Name in Full | ID No. | ID Type | Age |
| Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> | Address | | |
| Telephone No. | Relationship with the Insured | | |
| In what title are you submitting this claim? | Bank Account no. <input type="text"/> | | |

DECLARATION AND AUTHORIZATION

I/We hereby declare that the information given on this accident/hospitalization claim application form is true and complete.

I/We hereby make claim to Tata AIA by submitting this accident/hospitalization 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 accident/hospitalization claim application form shall constitute and are hereby made part of this accident/hospitalization claim application form. I/We further agree that the furnishing of this accident/hospitalization claim application form, or of any other forms supplemental hereto by the Company, shall not be deemed an admission of an existence of any assurance in force on the life in question, nor an admission of liabilities or a waiver of any of its rights of defenses.

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 hereby irrevocably authorize: (i) 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; (ii) the Company and its approved medical examiners and laboratories to perform medical assessment and tests to evaluate Insured's health condition, or to perform any autopsy as appropriate.

This authorization shall bind my/the Insured's successors and assigns and remain valid notwithstanding my/the Insured's health or incapacity in so far as legally possible. A photocopy of this authorization shall be as valid as the original.

| | |
|---|--|
| Witness Signature: _____ | Life Insured Signature: _____ |
| Date: _____ | Date: _____ |
| Name of Witness: _____ (in block letters, family name first) | Policyowner/Claimant (If other than life Insured) Signature: _____ |
| | Name: _____ (in block letters, family name first) |
| | Date: _____ |

Note: - Witness should be a Notary/ Gazetted officer /Gram Panchayat Pradhan/Gram Panchayat member/Doctor/Lawyer/School headmaster/Ward councilor/Block Development Officer/NGO/ Bank Manager/BOI/BOE/CSO/Zone claims person/Branch claims person/ZCSM/ SEM or a person of local standing.

Registered and Corporate Office : Tata AIA Life Insurance Company Ltd. (IRDA Reg. No. 110),14th Floor, Tower A, Peninsula Business Park, Senapati Bapat Marg, Lower Parel, Mumbai 400013. CIN: U66010MH2000PLC128403
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