Star Union Dai-ichi Life Insurance

A joint venture of Bank of India | Union Bank of India | Daiichi Life

CRITICAL ILLNESS OR DISABILITY RIDER CLAIM FORM

(FOR SUD OFFICIAL USE ONLY)

BRANCH NAME		BRANCH CODE	
INTERACTION ID			
EMPLOYEE NAME			
EMPLOYEE CODE		SIGN	
DATE	D D M M Y Y Y Y	TIME	☐ On or Before 3PM ☐ After 3PM

Photograph of Claimant Beneficiary/Nominee

☐ Critical Illness (Eg: Cancer/Stroke etc.) ☐ Disability/Paralysis (Due to Accident)

Note:
1. Critical Illness is not a Mediclaim and will not cover unexpected medical expenses and hospitalization. The critical illness policy acts as a supplementary layer of financial protection. Critical illness insurance provides a lump sum that can be used to manage the broader financial burden of a serious disease.
2. Health Claim Intimation can be submitted by Life Assured / Claimant (A close relative of the life assured or policyholder or The Bank Branch Manager)
3. Submission of complete medical documents will ensure swift and smooth claim processing.

SECTION A*

POLICY DETAILS

POLICY NO(S).	

SECTION B*

DETAILS OF LIFE ASSURED (LA)

NAME OF LIFE ASSURED	☐ Mr. ☐ Ms. FIRST MIDDLE LAST
FATHER NAME	FIRST MIDDLE LAST
DATE OF BIRTH	D D M M Y Y Y Y
ADDRESS	PIN CODE
CONTACT NO.	
EMAIL ID	
FAMILY DOCTOR	NAME REGISTRATION NO. CONTACT NO.
DOCTOR WHO CONFIRMED DEATH (IF APPLICABLE)	NAME REGISTRATION NO. CONTACT NO.
POLITICALLY EXPOSED PERSON	☐ Yes ☐ No
US PERSON	☐ Yes ☐ No (If Yes, please fill FATCA / CRS certification)

DETAILS OF CRITICAL ILLNESS

CLAIM SUBMITTED FOR (PLEASE TICK ANY ONE OF THE BELOW)

☐ Heart Related ☐ Cancer ☐ Brain ☐ Coma ☐ Multiple Sclerosis ☐ Paralysis
☐ Kidney Failure ☐ Major Organ Transplant ☐ Burn ☐ Blindness ☐ Liver ☐ Lung
☐ Others *Please specify*

EXACT DIAGNOSIS	
DATE OF DIAGNOSIS / SURGERY	D D M M Y Y Y Y
DATE OF FIRST CONSULTATION	D D M M Y Y Y Y

INFORMATION ABOUT THE DOCTOR(S) CONSULTED AND HOSPITALS FROM WHERE TREATMENT WAS TAKEN

S. NO.	NAME OF DOCTOR	HOSPITAL CONTACT NUMBER	DATE OF FIRST CONSULTATION	TREATMENT TAKEN

DETAILS OF DISABILITY

DATE OF DISABILITY	D D M M Y Y Y Y
DIAGNOSIS	
NATURE OF DISABILITY	(Tick anyone) ☐ Permanent ☐ Temporary
EXTENT OF DISABILITY	(Tick anyone) ☐ Total ☐ Partial

IS THE LIFE ASSURED CAPABLE OF PERFORMING THE FOLLOWING ACTIVITIES OF DAILY LIVING

☐ Dressing ☐ Using the Toilet ☐ Walking ☐ Feeding Him/Herself ☐ Using Telephone ☐ Bathing ☐ Taking Medication

Is the Life Assured capable of engaging in any gainful activity or carrying out any work, occupation, or profession to earn or obtain any wages, compensation, remuneration or profit

INFORMATION ABOUT THE DOCTOR(S) CONSULTED AND HOSPITALS FROM WHERE TREATMENT WAS TAKEN

S. NO.	NAME OF DOCTOR	HOSPITAL CONTACT NUMBER	DATE OF FIRST CONSULTATION	TREATMENT TAKEN

NATURE OF ILLNESS AND HABIT OF THE INSURED

Date of diagnosis of illness

☐ Hypertension ☐ Diabetes ☐ Heart Disease ☐ Liver Disease ☐ Kidney Disease

☐ Cancer ☐ Other *Please specify*

☐ Smoking ☐ Tobacco ☐ Alcohol ☐ Others (Please Specify)

(Please tick applicable (if Yes, for any of above) Duration of Consumption & Quantity Consumed

CONDITION

EXACT DATE OF DIAGNOSIS D D M M Y Y Y Y

DURATION

TREATMENT TAKEN FOR SAME

OTHER INSURANCE DETAILS WITH SUD LIFE & OUTSIDE SUD LIFE: INCLUDING LIFE INSURANCE AND HEALTH INSURANCE

POLICY NO.	COMPANY NAME	SUM ASSURED	LIFE/HEATH/ GROUP/ OTHERS	STATUS (ACTIVE/LAPSED/CLAIM APPLIED/MATURED)
1.				
2.				
3.				

☐ Death of Life Assured ☐ Severe Condition of Life Assured (Unable to fill & sign the health claim form)

DATE OF DEATH OF LIFE ASSURED D D M M Y Y Y Y

DETAILS OF LIFE ASSURED/CLAIMANT BENEFICIARY/NOMINEE – In case of Death of Life Assured or Severe condition and life assured is unable to fill and sign the health claim form. (In case of more than one claimant for policies with SUD Life, separate forms need to be filled for each claimant)

DATE OF BIRTH D D M M Y Y Y Y

CLAIMANT BENEFICIARY/NOMINEE NAME ☐ Mr. ☐ Ms. FIRST MIDDLE LAST

ADDRESS

PIN CODE

CONTACT NO. OFFICE RESIDENCE MOBILE

OFFICE &/OR PERSONAL EMAIL ID

RELATION WITH THE LIFE ASSURED ☐ Spouse ☐ Children ☐ Parents ☐ Others *please specify*

CLAIMANT'S BENEFICIARY/ NOMINEE TITLE ☐ Nominee ☐ Executor ☐ Trustee ☐ Appointee ☐ Employer ☐ Assignee ☐ Beneficiary

CLAIMANT'S BENEFICIARY/NOMINEE PAN DETAILS Or Form 60 ☐ (If Yes, Please submit the copy)

POLITICALLY EXPOSED PERSON ☐ Yes ☐ No

US PERSON ☐ Yes ☐ No (If Yes, please fill FATCA/CRS certification)

LIFE ASSURED/NOMINEE (only in case of death of life assured) NEFT MANDATE/ BANK ACCOUNT DETAILS

In case of children's plans, if beneficiary is a major, please provide beneficiary's account details

ACTIVE BANK ACCOUNT NO.

If accepts credit of more than 1 lakh ☐ Yes ☐ No

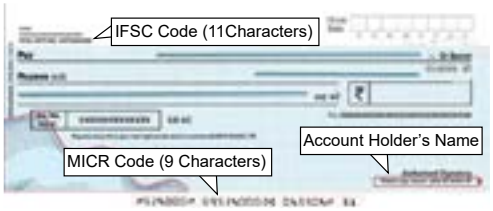
ACCOUNT HOLDER NAME

BANK NAME & BRANCH

ACCOUNT TYPE ☐ Savings ☐ Current ☐ NRO ☐ NRE

IFSC

MICR



Mandatory for Pension Plans, Please indicate how you would like to receive the benefits

☐ Entire amount as lumpsum ☐ Entire amount as Annuity ☐ Part as annuity Part as Lumpsump ☐ As Installments

Blank space for companies to input product specific payout methods

SECTION C*

DECLARATION AND AUTHORISATION

- I here declare all the details filled/furnished above are true correct to the best of my knowledge & belief.
- I hereby warrant the truth and correctness of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppress or conceal any material fact, my right to claim may be absolutely forfeited.
- I understand and agree that the submission of this form does not mean that the request will be processed for payment.
- I understand that any payout under the policy shall be strictly in accordance with the policy terms and conditions.
- Any payment shall be subject to realization of the last renewal premium payment.
- I authorise all the medical establishments (medical labs included), government institutions (police, revenue, etc.) to reveal the treatment information including any retro-viral diseases and others, related to the LA, to Star Union Dai-ichi Life, from both the past and present.
- A photocopy of this declaration shall be considered as valid and effective.
- I authorise Star Union Dai-ichi Life to share and obtain information on behalf of me with any reinsurer, insurance association, medical authorities, other insurers, statutory authorities, employer, court, governmental body, regulator using an investigation agency or other service hereby provide my consent for the same.

- Beneficiary/Nominee consent as per regulatory requirement: Loan Account Number and Outstanding loan amount as on date of death mentioned on claim form is accurate as per loan account statement and as per regulatory requirement, Insurers are required to pay the outstanding loan amount as on date of death to life assured's loan account and any balance payment (if any) will be paid to beneficiary.
- The Insured member/Nominee/Beneficiary who had submitted the Claim Statement form is the same person who has been registered by the Master Policy holder as the Insured Member/ Nominee/ Beneficiary under the Group Master Policy.
- Star Union Dai-ichi Life Insurance Company reserves the right to ask for more information/ documents, if required.

Date: D D M M Y Y Y Y

Place: _____

Signature

Signature of Life Assured/Claimant/Beneficiary/Nominee

DECLARATION TO BE MADE BY A THIRD PERSON (In case of Thumb impression/ Non-English signature)

The Policyholder has affixed his/her thumb impression/has signed in vernacular/has not filled the application. I hereby declare that the content of this application form has been explained to the Policyholder in _____ language and have truthfully recorded the answers provided to me. I further declare that the Policyholder has signed/affixed his/her thumb impression in my presence.

Name of the Declarant: _____

Address: _____

_____

Date: D D M M Y Y Y Y Place: _____

Signature of Declarant

Important Note: In case of any demand or favour asked by anyone including a company representative towards claim processing or settlement, the same should not be entertained and must be reported to the company immediately on the company's email id: claims@sudlife.in

Company Stamp & Signature of Authorised Signatory

INSTRUCTION FOR FILLING UP THE FORM

A. IMPORTANT INFORMATION (Please read before filling the form)

1. Claims under multiple policies may be registered by filling a single form & providing all applicable policy numbers
2. In case of more than one claimant beneficiary/nominee, separate forms need to be filled for each claimant beneficiary/nominee
3. If the claim belongs to different type such as insurance on loan or PMJJBY scheme or Health,seperate claim form corresponding to the type need to be filled
4. Please read the declarations carefully and the claimant beneficiary/nominee should sign the claim form in the same manner as you normally sign your cheque
5. Claim is payable subject to fulfillment of all terms and conditions of the policy
6. No fee or commission is required to be paid to anyone to process this claim
7. In case of valid full/partial assignment of policy,require declaration from assignee regarding outstanding due against security of policy with assignee/payee NEFT mandate because assignment affect the rights of the nominee only to the extent of the interest of the transferee or assignee in the policy
8. Make sure your address, phone numbers and email ID are current and active as the correspondence will happen through this only
9. Asterisk (*) refers to mandatory information
10. Under Critical Illness benefit, need to check waiting period applicability for your policy.
    - Waiting period starts from risk commencement date or revival post discontinuance of premium.
    - Any critical illness diagnosed within the waiting period will not be considered for benefit
11. Please refer your policy document for applicable survival period, waiting period, cooling of period along with any exclusion clauses and also check for applicable list of critical illness along with the definition and corresponding amount
12. Condolence calling will be done from head office and they may ask for any specific information and additional medical documents related to your illness/disability
13. Wherever required the company may appoint medical practitioners to verify the disability / critical illness condition of the life assured

B. DOCUMENTS TO BE SUBMITTED

MANDATORY DOCUMENTATION AT THE POINT OF CLAIM NOTIFICATION

LIST OF DOCUMENTS	LIST OF DOCUMENTS
Critical Illness: 1. Health Claim Form 2. Life Assured ID and Address proof 3. Printed Life Assured Bank Passbook/ Cancelled cheque 4. Self-Attested copy of Claimant ID and Address proof (If different than life assured) 5. Printed Nominee Bank Passbook/ Cancelled cheque (Only in case of death of life assured) 6. Diagnostic report confirming CI 7. Definition Fulfilment Document (All hospital medical reports, case histories, investigation/diagnosis reports, treatment papers, discharge summaries, precise diagnosis of the treatment for which a claim is made) in case the Member was treated for any illness related to the cause of critical illness/disability/death 8. Any other document or information that we may need to process the claim depending on the cause or nature of the claim 9 Original Death Certificate / Attested copy of death certificate (In case of death)	**Disability Rider/ Living Benefits:** 1. Health Claim Form 2. Life Assured ID and Address proof 3. Printed Life Assured Bank Passbook/ Cancelled cheque 4. Self-Attested copy of Claimant ID and Address proof (If different than life assured) 5. Printed Nominee Bank Passbook/ Cancelled cheque (Only in case of death of life assured) 6. Disability certificate 7. First Information Report 8. Postmortem Report/Autopsy Report 9. Certified copy of the Viscera report if available 10. Definition Fulfilment Document (All hospital medical reports, case histories, investigation/diagnosis reports, treatment papers, discharge summaries, precise diagnosis of the treatment for which a claim is made) in case the Member was treated for any illness related to the cause of critical illness/disability/death 11. Any other document or information that we may need to process the claim depending on the cause or nature of the claim 12. Original Death Certificate / Attested copy of death certificate (In case of death)

PTO

Disclaimers: Copies to be submitted and originals to be presented at the time claim submission,

C. LIST OF VALID IDENTITY & ADDRESS PROOFS (Please tick the document submitted)

PHOTO IDENTIFY PROOF (ANY ONE)

- ☐ Claimant's Beneficiary/Nominee PAN CARD
- ☐ Valid Passport
- ☐ Voter ID Card
- ☐ Masked Aadhar Card Copy* (First 8 digits only)
- ☐ Valid Driving License
- ☐ Bank Passbook with stamped photograph (not more than 6 months old)
- ☐ ID Card Issued by Central/State Govt. to employee
- ☐ Any other Central/State Govt. issued ID

ADDRESS PROOF (ANY ONE)

- ☐ Valid Passport
- ☐ Voter ID Card
- ☐ Masked Aadhar Card Copy* (First 8 digits only)
- ☐ Valid Driving License
- ☐ Bank Passbook with stamped photograph (not more than 6 months old)

*I voluntarily provide my consent to use my Aadhar to conduct identity check towards KYC compliance by Star Union Dai-ichi Life Insurance

D. NOTE: CLAIMANT BENEFICIARY/NOMINEE NEFT MANDATE/ BANK ACCOUNT DETAILS

- A cancelled personalised cheque with the account no. and IFSC should be submitted along with the NEFT mandate. If the cheque is not personalised, a latest bank statement or copy of passbook (where account number and IFSC is mentioned) needs to be submitted with the mandate
- This mandate, upon processing, will override any of the previously tagged NEFT mandates for all policies, held by the client with Star Union Dai-ichi Life.
- In case of NEFT failure or any further requirements pending on the mandate, payout will be kept on hold till fresh NEFT mandate is received. Intimation will be sent to you for the same

[#] Refund to NRE account (full or proportionate) will be subject to ratio of premium(s) paid through NRE Account. Please submit a Bank Statement or Bank Confirmation letter as an evidence for premium(s) paid through NRE account.

[##] In case of proportionate payout, for more than one nominee, please provide respective nominee's NEFT mandates i.e. for NRE account and non-NRE account.

CUSTOMER ACKNOWLEDGEMENT COPY - CRITICAL ILLNESS OR DISABILITY RIDER CLAIM FORM

POLICY NO.		CLAIMANT BENEFICIARY/NOMINEE NAME	
BRANCH NAME / INTERACTION ID		CLAIMANT BENEFICIARY/NOMINEE CLIENT ID	
EMPLOYEE NAME		EMPLOYEE CODE	
DATE	D D M M Y Y Y Y	EMPLOYEE SIGN	

Branch Stamp

Star Union Dai-ichi Life Insurance Company Limited

Registered Office: Unit No. 1101, 11th Floor, Building No. 1, Raheja Mindspace Juinagar, Plot No. GEN 2/1/E, TTC Industrial Area, MIDC Juinagar, Navi Mumbai – 400 706. • Toll Free No.: 1800 266 8833 (9.00 am to 7.00 pm - Mon to Sat)

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