



**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](http://www.pnbmetlife.com), Email: [indiaservice@pnbmetlife.co.in](mailto: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

<b>POLICY NUMBER</b>																				
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**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. Countersign 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 DISABILITY:**

Name of the Doctor: _____	
Name of the Hospital: _____	
Address: _____	
Contact No.: _____	E-mail address: _____

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

<input type="checkbox"/> Loss of sight of one Eye	<input type="checkbox"/> Loss on use of one Limb	<input type="checkbox"/> Loss of sight of both the eyes
<input type="checkbox"/> Loss of Hearing	<input type="checkbox"/> Loss of use of two limbs	<input type="checkbox"/> Loss of one limb & loss of sight of one eye
<input type="checkbox"/> Loss of speech and hearing	<input type="checkbox"/> Loss of Speech	

**Note:** In case of disability due to Accident, kindly fill additional Doctor's Certificate available for Accidental Disability

**DETAILS OF ACCIDENT:**

Cause of Accident: _____	
Date of Accident: _____	
Is FIR lodged:	<input type="checkbox"/> Yes <input type="checkbox"/> 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**.

I/We hereby further consent, and duly authorize, PNB MetLife to use, store, share, transfer and disclose any of the personal and sensitive information of mine/our collected or available with PNB MetLife (whether contained in this document or obtained otherwise) which may include but not limited to my KYC documents to any individual / organization / entity associated or affiliated with or engaged by PNB MetLife, including reinsurers, claim investigative agencies, vendors and industry associations/ federations, for the purpose of processing this claim and / or for providing subsequent services.

Signature/Left Thumb impression of claimant: \_\_\_\_\_ Date: \_\_\_\_\_

Name &amp; 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.