pnb MetLife
LIFE INSURANCE

CLAIM FORM - PART A

PART A TO BE FILLED IN BY THE INSURED

The issue of this Form is not to be taken as an admission of liability

IMPORTANT INSTRUCTIONS:

The submission of the filled-up claim form, along with the required mandatory documents, is not to be construed as an admission of liabilities of our Company under the policy. No agent/intermediary has been or is authorized to admit any liabilities on behalf of the Company.

Early submission of this form along with the required mandatory documents, as provided below, will enable us to process your claim faster. PNB MetLife shall not be responsible for any delay in the processing of the claim on account of submission of incomplete claim form and/or non-submission of the mandatory documents

MANDATORY DOCUMENTS TO BE SUBMITTED ALONG WITH THIS FORM:

Mandatory Documents required for Hospital/ Surgical Cash Benefit CI and Critical Illness (CI) Rider Claim	Mandatory Documents required for Accidental Total & Permanent Disability (ATPD) Claim
• Claim form duly completed and signed by the Owner/ Proposer including Part B of Form filled by Hospital • Copy of Owner/ Proposer address proof • Copy of Owner/ Proposer photo identity proof • Copy of Insured Person(s) address proof • Copy of Insured Peron(s) identity proof • PAN/ Form 97 of the Owner/ Proposer • Copy of cancelled cheque/ bank statement/ bank passbook of the Owner/ Proposer • Copy of Discharge Summary confirming the surgery undergone (if any) • Copy of indoor case papers duly attested by the Hospital • Copy of past Medical Reports duly attested by the Hospital • Copy of Diagnostic/ Investigation reports duly attested by the Hospital • Copy of Final Bill	• Copy of Owner/ Proposer address proof • Copy of Owner/ Proposer photo identity proof • Copy of Insured address proof • Copy of Insured identity proof • PAN/ Form 97 of the Owner/ Proposer • Copy of cancelled cheque/ bank statement/ bank passbook of the Owner/ Proposer • Copy of Discharge Summary confirming the surgery undergone (if any) • Copy of Indoor case papers/ Past Medical Reports • Copy of Diagnostic/ Investigation reports • Copy of First Information Report (FIR) from the police authority/ general diary entry, Medico-legal certificate • Proof of 6 month continuous disability • Copy of Medical practitioner certification of permanent & total disability • Copy of Disability Certificate Issued by Govt. Civil Surgeon/ Authorized Specialist

SECTION A: DETAILS OF THE CLAIMANT

Name: _____ Date of Birth: DD/MM/YYYY Gender: ☐ Male ☐ Female

Address (Current Residential Address): _____

_____

City: _____ Pin Code: _____ State: _____

Contact Number: Landline: _____ Mobile: _____

Email ID: _____ PAN No./Form 97: _____

Occupation: ☐ Salaried ☐ Self Employed ☐ Business ☐ Professional ☐ Others

Employer name and Address: _____

Section B: DETAILS OF THE INSURED

Name: _____ Date of Birth: DD/MM/YYYY Gender: ☐ Male ☐ Female

Address (Current Residential Address): _____

_____

City: _____ Pin Code: _____ State: _____

Contact Number: Landline: _____ Mobile: _____

Email ID: _____ PAN No./Form 97: _____

Occupation: ☐ Salaried ☐ Self Employed ☐ Business ☐ Professional ☐ Others

Employer name and Address: _____

Section C: MEDICAL HISTORY OF LIFE INSURED

a) Name of Hospital where Admitted: _____

b) Room Category Occupied: _____

c) Hospitalization due to: Injury/ Illness / Maternity

d) Describe initial symptoms/ Part of body injured: _____

e) Since when does the Insured have this symptoms/ injury? _____

f) Diagnosis by Attending Doctor for first Doctor Consulted _____

g) Date of Injury / Date Disease first detected /Date of Delivery: DD/MM/YYYY

h) Date of Admission: DD/MM/YYYY a) Time: HH/MM

i) Date of Discharge: DD/MM/YYYY b) Time: HH/MM

j) If Injury give cause: Self-inflicted / Road Traffic Accident / Substance Abuse/Alcohol Consumption c) If Medico legal case / FIR done: Yes/No

k) Any surgical procedure done during hospitalization give details: Yes/No

Section D: HEALTH/ HABIT DETAILS OF LIFE ASSURED:

NATURE OF ILLNESS & HABITS (Please select)	Duration (since when)	Duration (since when)
☐ Hypertension ☐ Diabetes ☐ Heart disease ☐ Liver disease ☐ Kidney disease ☐ Cancer		
Any other ailments/ disorder/ surgery/ hospitalization in last 5 Yr		
☐ Smoking ☐ Alcohol ☐ Tobacco ☐ Drugs		

Did a medical leave certificate was filed to Insured's employer? ☐ Yes ☐ No

Are you entitled to any benefits from another insurer, institution, or government welfare scheme for the same cause: ☐ Yes ☐ No

If yes, Company/ Scheme Name _____

Section E: PARTICULARS OF OTHER HEALTH INSURANCE/ MEDICLAIM POLICIES HELD BY THE LIFE ASSURED:

Name of the Company/ TPA	Policy No. Date	Risk Commencement	Sum Assured	Claim Raised Yes/ No	Illness/ Disease	Date of Illness

Section F: DETAILS OF DOCTORS CONSULTED AND HOSPITALS /MEDICAL CENTERS VISITED FOR CURRENT OR SIMILAR ILLNESS IN PAST:

Sr. No.	Name of the Doctors/ Hospitals/ Medical Centers	Date of first consultation	Address	Registration No. of Doctor/ Hospitals	Date of Admission & operation	Date of Discharge

SECTION G: DETAILS OF LUMPSUM/ CASH BENEFIT CLAIMED:

☐ Silver - 10 Critical Illness (CI) Benefit	☐ Surgical Cash Benefit (SCB) – Option 1
☐ Gold - 20 Critical Illness (CI) Benefit	☐ Surgical Cash Benefit (SCB) – Option 2
☐ Platinum - 60 Critical Illness (CI) Benefit	☐ Hospital Cash Benefit (HCB)
☐ Day Care Option	☐ Accidental Permanent Disability

SECTION H: DETAILS OF CLAIM AMOUNT

DETAILS OF CLAIM AMOUNT					
Sr. No	**Bill No.**	**Bill date**	**Towards**	**Particulars**	**Amount**
1					
2					
3					
4					
Total					

SECTION I: INFORMATION ABOUT THE CRITICAL ILLNESS CLAIMED: ☐ GOLD ☐ PLATINUM ☐ SILVER

Sr No	Name of CI / Surgery	Gold	Silver	Platinum	Sr No	Name of CI / Surgery	Gold	Silver	Platinum
1	Cancer of Specified Severity	✓	✓	✓	31	Creutzfeldt-Jakob disease	NA	NA	✓
2	Myocardial Infarction (First Heart Attack of specific severity)	✓	✓	✓	32	Dissection of Aorta	NA	NA	✓
3	Open Chest CABG	✓	✓	✓	33	Eisenmenger's Syndrome	NA	NA	✓
4	Coma of Specified Severity	✓	✓	✓	34	Elephantiasis	NA	NA	✓
5	Open Heart Replacement or Repair of Heart Valves	✓	✓	✓	35	Encephalitis	NA	NA	✓
6	Multiple Sclerosis with Persisting Symptoms	✓	✓	✓	36	Hemiplegia	NA	NA	✓
7	Blindness	✓	✓	✓	37	Infective Endocarditis	NA	NA	✓
8	Deafness	✓	✓	✓	38	Medullary Cystic Disease	NA	NA	✓
9	End Stage Liver Failure	✓	✓	✓	39	Myasthenia Gravis	NA	NA	✓
10	End Stage Lung Failure	✓	✓	✓	40	Pheochromocytoma	NA	NA	✓
11	Major Organ/ Bone Marrow Transplant	NA	✓	✓	41	Progressive Supranuclear Palsy – resulting in permanent symptoms	NA	NA	✓
12	Permanent Paralysis of Limbs	NA	✓	✓	42	Progressive Scleroderma	NA	NA	✓
13	Motor Neuron Disease with Permanent Symptoms	NA	✓	✓	43	Poliomyelitis	NA	NA	✓
14	Loss of Speech	NA	✓	✓	44	Severe Rheumatoid Arthritis	NA	NA	✓
15	Kidney Failure Requiring Regular Dialysis	NA	✓	✓	45	Systemic Lupus Erythematous	NA	NA	✓
16	Stroke Resulting in Permanent Symptoms	NA	✓	✓	46	Tuberculosis Meningitis	NA	NA	✓
17	Loss of Limbs	NA	✓	✓	47	Muscular Dystrophy	NA	NA	✓
18	Major Head Trauma	NA	✓	✓	48	Benign Brain Tumour	NA	NA	✓
19	Primary (Idiopathic) Pulmonary Hypertension	NA	✓	✓	49	Amputation of Feet Due to Complications from Diabetes	NA	NA	✓
20	Third Degree Burns	NA	✓	✓	50	Severe Crohn's Disease	NA	NA	✓
21	Alzheimer's Disease	NA	NA	✓	51	Loss of One Limb and One Eye	NA	NA	✓
22	Aorta Graft Surgery	NA	NA	✓	52	Myelofibrosis	NA	NA	✓
23	Fulminant Hepatitis	NA	NA	✓	53	Necrotising Fasciitis	NA	NA	✓
24	Loss of Independent Existence (cover up to Insurance age 74)	NA	NA	✓	54	Other Serious Coronary Artery Disease	NA	NA	✓
25	Parkinson's disease	NA	NA	✓	55	Severe Ulcerative Colitis	NA	NA	✓
26	Apallic Syndrome or Persistent Vegetative State (PVS)	NA	NA	✓	56	Terminal Illness	NA	NA	✓
27	Bacterial Meningitis	NA	NA	✓	57	Pneumonectomy	NA	NA	✓
28	Brain Surgery	NA	NA	✓	58	Aplastic Anaemia	NA	NA	✓
29	Cardiomyopathy – of specified severity	NA	NA	✓	59	Chronic Relapsing Pancreatitis	NA	NA	✓
30	Chronic Adrenal Insufficiency	NA	NA	✓	60	Multiple System Atrophy	NA	NA	✓

Section J: Payment Details of Claimant – NEFT

Name of Account Holder: _____

Bank & Branch Name: _____

Account No.: _____

IFSC: _____ MICR: _____

Account Type: _____ Savings: _____

Please attach a copy of cancelled Cheque or Bank Passbook copy for verifying details.

Section K: DECLARATION & AUTHORIZATION

I do hereby declare that all the above statements are true and complete and that nothing has been suppressed or with - held from my side. I understand that in furnishing claim form PNB MetLife has not admitted liability or waived any of its rights under the policy. 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 or furnish the records 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 authorize, PNB MetLife to use and disclose any of the personal and sensitive information of mine/our collected or available with PNB MetLife (whether contained in this statement or obtained otherwise) which may include KYC documents to any individual / organization / entity associated or affiliated with or engaged by PNB MetLife, including reinsurers, claim investigative agencies, vendors and industry association / federations, for the purpose of processing this claim and/or for providing subsequent service.

Signature/Left Thumb impression: _____ Date: _____

:

Declaration by the person filling in the Claim form. (in case the Claim form is filled up / signed in a language other than the claimant's own).
I hereby declare that I have fully explained the contents of the Claim form to the claimant in the language understood by him/her. The same has been fully understood by him/her and the replies have been recorded as per the information provided by the claimant and the replies have been read out to, fully understood and confirmed by the claimant.

The content of the form and document have been fully explained to me and that I have fully understood the content mentioned herein and its significance for the proposed Claim

Date	Place	Signature of Declarant/ Witness	Signature / Left thumb Impression Claimant/ Nominee

Name of Witness/ Declarant: _____ **Signature of Witness/ Declarant:** _____

Address of Witness/ Declarant: _____

Claimant relation with Witness/ Declarant: _____

Date: _____ **Place:** _____

CUSTOMER ACKNOWLEDGEMENT COPY*

Policy No. _____ Claimant Name: _____

Branch Name / Intimation Number: _____ Claimant Client ID: _____

Employee Name: _____ Date: _____

Employee Signature: _____ Employee Code: _____

IRDAI Registration No: _____

Branch Stamp

*The acknowledgment slip should not be construed as acceptance of claim. The Company reserves the right to call for additional documents

CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

The issue of this Form is not to be taken as an admission of liability

IMPORTANT INSTRUCTIONS:

The submission of the filled-up claim form, along with the required mandatory documents, is not to be construed as an admission of liabilities of our Company under the policy. No agent/intermediary has been or is authorized to admit any liabilities on behalf of the Company.

Please Counter-sign where amendments/alterations are made in the form.

SECTION A - DETAILS OF HOSPITAL

Name of the Hospital: _____

Hospital ID: _____

Type of Hospital: ☐ Network ☐ Non-network

Name of the treating doctor: _____

Qualification: _____

Registration No. with State Code: _____

Contact No.: _____

SECTION B - DETAILS OF THE INSURED

Name of the Patient: _____

IP Registration No.: _____

Gender: ☐ Male ☐ Female

Date of Admission: DD/MM/YYYY

Date of Discharge: DD/MM/YYYY

Type of Admission: ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity

Type of Management: ☐ Surgical ☐ Medical ☐ Both

Primary Diagnosis: _____

Name of the Procedure or treatment: _____

Co-morbidities: _____

Past Medical/ Surgical history of patient: _____

Status at the time of discharge: ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased

Total Claimed Amount: _____

SECTION C - ADDITIONAL DETAILS IN CASE OF NON-NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital: _____

_____

_____

_____

City: _____

State: _____ Pin Code: _____

b) Contact No: _____

c) Registration No. with State Code: _____

d) Hospital PAN: _____ e) No. inpatient beds: _____

f) Facilities available in the hospital: ☐ Operation THEATRE ☐ ICU

SECTION D - DECLARATION BY THE HOSPITAL

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material facts, our right to claim under this claim shall be forfeited.

Date: DD/MM/YYYY

Signature & Seal of the Hospital _____

Authority: Place: _____