



YOUR PARTNER FOR PROSPERITY

associated with  Sanlam group

BRANCH /D.O SEAL

RIDER CLAIM INTIMATION

**Instruction for filling up the form**

- This form is to be filled for ALL Rider Claims.
- This Form needs to be filled in by the Life Insured.
- Please submit this form along with the requirements mentioned below at the nearest branch Or  
**Claims Department, 5<sup>th</sup> Floor, Plot # 31 & 32, Ramky Selenium Financial District, Gachibowli, Hyderabad - 500032**
- The Company reserves the right to call for any information / additional document(s) /Requirement(s) as it may deem necessary.
- **Every field should be properly and correctly filled up. Please ensure complete details are provided.**

**DOCUMENTS TO BE SUBMITTED**

To be Submitted (Documents)	Critical Illness		Accident Disability Rider		Non-Accident Disability Rider	
	Req	Y/N	Req	Y/N	Req	Y/N
<b>Mandatory</b>						
Duly filled Rider Claim Intimation Form	✓		✓		✓	
Original Policy Documents	✓		✓		✓	
Life Insured's Photo, Current Address Proof & Photo ID Proof	✓		✓		✓	
Life Insured's copy of Bank Passbook/Statement with account details	✓		✓		✓	
Medical Records (Consultation notes, treatment records, admission notes, hospital indoor case papers, discharge summary, investigation reports etc)	✓		✓		✓	
Physician Statement	✓		✓		✓	
Copy of duly certified First Information Report / Inquest /Panchnama (translation mandatory in case of vernacular language)	×		✓		×	
Copy of Driving License if the Life Insured was driving the vehicle at the time of accident.	×		✓		×	
Disability Certificate from Government Authority	×		✓		✓	
Settlement Option (if applicable)	×		×		×	
Any other Document (Please specify) _____						
<b>Life Insured Details</b>						
<b>Name (full name)</b> _____						
<b>Address</b>		<b>Permanent</b>		<b>Current</b>		
<b>State</b>		<b>PIN</b>		<b>State</b>		<b>PIN</b>



Details of Accident Rider Claim			
Date of accident		Details of Accident	
Details of Treatment/Hospitals after the Accident			

#### Authorisation & Declaration

Notwithstanding the provisions of any law, usage, custom or convention for the time being in force prohibiting any physician or Hospital or any other authority from divulging any knowledge or information acquired by him / her / them in attending upon or examining a person on the ground of secrecy, I hereby authorise any physician and any Hospital who has attended upon or examined or treated the aforesaid life assured for any ailment or illness or any other authority to divulge any knowledge or information regarding the person's state of health which he / she / they may have acquired whether before or after the policy was issued by Shriram Life Insurance Co Ltd., to any of the authorized representatives of Shriram Life Insurance Co Ltd or at any of its offices or in any court of law.

I, \_\_\_\_\_, do hereby; declare that the statements made herein above are true and complete in each and every respect. I understand that any incorrect or incomplete or misleading information in this form shall affect the claim settlement process and the decision of the Company. I agree to assist the Company in Claims Investigation. I also understand that in furnishing claim forms, Shriram Life Insurance Co Ltd has not admitted liability or waived any of its rights.

Date

Signature/Thumb Impression of Life Insured/Claimant

Name of Witness

Contact No:

Signature:

Address:

**This is just an intimation of Claim to the Company. This intimation is not admittance of the Claim by the Company.**