IDBI FEDERAL
In association with Ageas
IDBI Federal Life Insurance Co Ltd

IRDA Regn. No. 135. | Corporate Identity Number: U66010MH2007PLC167164.
22nd Floor, A Wing, Marathon Futurex, N. M. Joshi Marg, Lower Parel (E). Mumbai - 400013.
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www.idbifederal.com

WAIVER OF PREMIUM BENEFIT CLAIM FORM FOR DEATH/ DISABLEMENT

Lodged at:
Head Office: ☐ Branch Office: ☐ _____

(To be completed by the Policy Owner/ Legal Representative)

General instructions and warnings:

- While answering the question in the claim form and providing any other information in respect of the claim, the Claimant must make a full and frank disclosure of all material facts.
- Please read the policy document carefully to avail the benefits under the policy.
- All corrections made in the claim form have to be duly countersigned in full.
- All the answers must be clear and unambiguous.
- If the space provided is insufficient, please attach the annexures along with this form.
- Please submit the requisite documents along with the claim form for a faster processing.
- The Company retains the right to call for further evidence needed to process the claim.
- Submission of form duly acknowledged by us does not amount to admission of claim.

Checklist of the documents to be submitted in case of Waiver of Premium benefit

A. Waiver of Premium benefit on death or disablement of the Policy Owner (in case the person to be insured and policy owner are two different individuals):

☐ Waiver of Premium for Death/Disablement Claim form (available on the website /can be provided by the claims department).
☐ Original certificate of death or disablement. (will be returned after verifying)
☐ Physician`s Statement stating the cause of death (format will be provided by the claims department).
☐ Attested copies of Hospital Treatment Certificate with relevant medical/test records by the respective hospitals

B. Waiver of Premium benefit on disablement of the Life Insured:

☐ Waiver of Premium for Death/ Disablement Claim form (available on the website /can be provided by the claims department).
☐ Disability Certificate (will be provided by the claims department)/ Attested copy of disability certificate by attending physician / institute.
☐ Attested copies of Hospital Treatment Certificate with relevant medical/test records by the respective hospitals

Note:

1 **If copies of any documents are being submitted then, they need to be attested by the respective authorized signatories / entities from where they were issued.**
2 **Depending on the facts and circumstances of the claim, the Company reserves the right to call for certain additional documents.**

Name of the Deceased/Life Insured:

Claim No: _____ Policy No(s): _____ Sum Insured: _____

1. Information about the Policy Owner:

i. Name of the Policy Owner _____
ii. Age _____
iii. Address _____
_____
iv. Occupation and Office address _____
_____
_____
v. Telephone number- Residence (with STD code) _____
Mobile number _____
vi. **Email ID & Fax No.** _____
vii. **Bank account no., Name of the Bank and address (mandatory)** _____
_____

2. Information about the Deceased/ Disabled:

i. Place of death or disablement _____

ii. Date and time of death or disablement _____

iii. Exact cause of death or disablement _____

iv. Period of disablement: i. Please specify when the disablement began and whether you have completely recovered from the disablement? If recovered, then please specify the total period of disablement? _____

_____

_____

v. Severity of Disability: _____

vi. Please specify the body parts affected by the illness / accident _____

_____

vii. Place and Date of registration of death _____

viii. Last residential address _____

_____

ix. Last occupation, address and tel.nos of the employer(s) _____

_____

x. Last date of employment _____

_____

xi. Names and addresses of relatives or other persons present at the time of death/Accident _____

_____

_____

xii. Please specify the details of cause of accident _____

_____

xiii. Names and addresses of anyone else injured/killed _____

_____

_____

xiv. Date and time of admission to the hospital _____

xv. Name, address and tel. nos. of the Doctor(s) consulted during the accident or illness _____

_____

_____

xvi. Details of treatment taken for any other illness _____

_____

_____

xvii. Name, Address and Tel. Nos. of doctor / hospital certifying the death/Disablement _____

_____

_____

_____

xviii. Hospitals where Treatment was given _____

_____

xix. Date and type of treatment/ Investigations undergone _____

_____

_____

xx. Date of Discharge _____

_____

xxi. Name, Address and the contact no of the Family Doctor, if any _____

xxii. Name and Address of Police Station (where Accident was reported) _____

_____

_____

xxiii. First information Report number and date of FIR _____

_____

xxiv. Was a postmortem carried out? Yes / No. If Yes, then please provide Name, Address and Tel. No. of hospital_____

_____

_____

_____

If it is road traffic accident, state the following however, if it is any other form of accident you may not fill up the below details:

i. Place of accident _____

ii. Registration numbers of vehicles involved _____

3. Details of policies on the Policy Owner / life insured taken with other life insurance companies:

S. No.	Base policy benefit	Base amount	Policy no.	Insurer	Effective Date	Riders

4. Declaration:

I _____do hereby declare and confirm that I am the Policy Owner /rightful Claimant of the deceased person and the statements made hereinabove are true and complete in each and every respect.

I hereby authorize any medical practitioner or hospital or nursing home or medical clinic who or which has attended upon or examined or treated me/Life Insured for any ailment or illness to divulge any knowledge or information regarding my/Life Insured's state of health which he / they may have acquired before or after the issuance of the policy, to IDBI Federal Life Insurance Co Ltd, any of its offices, Court of law, or any grievance redressal forum. I hereby confirm that this authorization is notwithstanding any law, custom or usage for the time being in force prohibiting any physician or hospital from divulging any knowledge or information, acquired by him/ them in attending upon or examining a person on the ground of secrecy.

Further, I hereby authorize any insurance company, government organization, employer, other organization, institution or person to release to IDBI Federal Life Insurance Co Ltd or its duly authorized representatives any records or knowledge about me /Life Insured. I hereby confirm that such information shall without limitation include information about my/Life Insured's health (including any information relating to the use of drugs or alcohol, AIDS, or mental and physical history, condition, advice or treatment), earnings or other insurance benefits, including any accounting information of my /life insured's account.

I hereby declare that I am entitled to make the above authorizations. I also agree to render help to IDBI Federal Life Insurance Co Ltd or its duly authorized representatives to gather the said information or any information that may help the company to process this claim and to use the information in whatever manner as may be deemed to be fit to process this claim further.

Name in Block Letters: _____

Address and telephone No: _____

_____

Signature / Thumb Impression of the Policy Owner: _____

Place: _____ Date: _____

5. Witness Declaration:

(The below Declaration is to be given if claim form is signed in vernacular or if the Claimant has used thumb impression instead of signature.)

I have explained the contents of this claim form to the Claimant in _____ (language) and ensured that the contents have been fully understood by him/her. I have accurately recorded the claimant's responses to the information sought in the claim form. I have read out the responses to the Claimant and he/she has confirmed that they are correct and affixed his/her thumb impression after fully understanding the same.

Name of Witness/ Declarant: _____

Address: _____

_____

Signature of the Witness/ Declarant: _____

Place: _____ Date: _____