

Claim No.: _____

LOSS OF LICENCE - CLAIM FORM

Policy Number:	
PARTICULAR'S OF CLAIM	
1) Name of Insured in Full:	
2) Residential Address:	
3) Business Address:	From DD / MM / YYYY To DD / MM / YYYY
4) Profession or Occupation:	
5) State nature of illness	
6) Have you ever suffered from the same or a similar complaint before?	
7) Are you insured elsewhere against illness? If so, give particulars.	
8) State the first day you were attended by a doctor and the name of the doctor.	
9) Has he or any other doctor attended you during the last five years for any illness or injury? If so, give particulars.	
10) Have you, as the direct result of the illness, been totally incapacitated from attending to business of any kind? If so, state for how long?	From DD / MM / YYYY To DD / MM / YYYY
11) Are you still totally incapable of attending to business of any kind?	
12) State if	
(a) Confined to bed	From DD / MM / YYYY To DD / MM / YYYY
(b) Confined to house	From DD / MM / YYYY To DD / MM / YYYY
13) If now able to attend to any portion whatever of your business or occupation, state when you commenced to do so.	
14) When and where can you be visited by our Medical or other Officer?	
15) If you are prepared to agree to an immediate settlement please state the amount you are willing to accept.	
I CERTIFY that to the best of my belief the foregoing statements are correct	
Date: _____	_____
Place: _____	Signature

THIS FORM IS TO BE COMPLETED BY THE CLAIMANT'S MEDICAL ATTENDANT WHOSE REPLIES SHOULD BE AS FULL AS POSSIBLE.

1) Name of the Claimant	
2) Nature of illness	
3) Please state the date on which the illness commenced	
4) When did Claimant first consult you in connection of present illness?	
5) Present condition (state as clearly as possible)	
6) Are you the usual Medical Attendant? If so, how long have you known him?	
7) Has the claimant in previously suffered from this complaint? If so, please state when?	
8) Is the claimant suffering from any disease irrespective of the present illness, or are there any other circumstances which may tend to delay recovery? If so, please give particulars.	
9) Is the claimant in your opinion unable to give any attention to his profession or occupation, as described on the front page, please state:	
(a) Date of commencement of total disablement	
(b) Probable future duration	
10) State if the claimant is by your advice:	
(a) Confined to bed	
(b) Confined to house	
11) If the Claimant is now able to take any part whatever in his profession or occupation please state from what date?	
12) Remarks	

Name of the Attending Doctor	
Qualifications	
Address	

Date: _____

Place: _____

Signature of the Attending Doctor

PEP DECLARATION:

Are you a Politically Exposed Person (PEP)?

☐ Yes ☐ No

If yes, please mention the position held

Is any of your close relation or family member a PEP?

☐ Yes ☐ No

If yes, please mention the name and relation and the position held by such close relative/family member.

I hereby declare that in future if me, any of my close relatives or any of my family member attains a position of PEP then I shall confirm the same to IndusInd General Insurance Co. Ltd as a mandate. I understand that this is a crucial information under the PMLA Rules and AML/CFT Guidelines and shall confirm that the answers given by me is true. In case the company comes to know that this is a misrepresentation and concealment of information then the policy shall be put on hold for scrutiny by the company and I shall be solely responsible for the same.

Note :

"Politically Exposed Persons" (PEPs) shall have the meaning assigned to it under sub clause (db) of clause (1) of Rule 2 of the Prevention of Money Laundering (Maintenance of Records) Rules, 2005."

(db) "Politically Exposed Persons" (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials".

AML Guidelines

1. I/We hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been /will be paid out of proceeds of crime related to any of the offense listed in Prevention of Money Laundering Act,2002.
2. I Understand that the Company has the right to call for document to established sources of funds.
3. The Insurance Company has right to cancel the insurance contract in case I am/have been found guilty by competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India.

Place: _____

Date: _____

Signature of Proposer

GENERAL DECLARATION:

I understand that as per the new AML/CFT Guidelines issued IndusInd General Insurance Co. Ltd will be verifying my details pertaining to KYC and PAN provided at the time of proposal.

I further, do hereby agree and consent that in the case of the event of a mismatch of information provided by me in the proposal form, identification proof, and address proof at the time of issuance of the policy. I request IndusInd General Insurance Company Limited to issue the policy with the details appearing as per my proposal form. I will be solely responsible for any consequences arising out of the difference in detail given by me during the verification of supporting documents provided by me at the time of issuance of the policy or otherwise.

HEALTH CARE ADDRESS:

Health Care Unit: IndusInd General Insurance, No.1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad - 500081. **Email:** healthcare@indusindinsurance.com.



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74004 22200 (WhatsApp)

