

Information regarding the Accident

Kind of Disability: _____

Place of Accident: _____

Date of Accident:

Time of Accident:

Cause of Accident (In case of non-road accident please skip 2, 3, and 4)

1. Type of Accident: _____

2. Make and Registration number of the vehicle Involved:

3. Name of the Registered Owner: _____

Registered Address: _____

Registered Telephone Number:

4. Name of the Driver: _____

Driver Address: _____

Driver Telephone Number:

5. Name of the other person involved: _____

Other person Address: _____

Other person Telephone Number:

6. Name of the witness to accident: _____

Witness Address: _____

Witness Telephone Number:

7. Date of Admittance to hospital: Time of Admittance to hospital:

8. Name of the hospital: _____

Hospital Address: _____

Hospital Telephone Number:

9. Details of attending Doctor: _____

10. Name of the police station where accident was reported: _____

Police station Address: _____

Police station Telephone Number:

11. Name of police officers who conducted the investigation: _____

12. Details of their Finding: _____

Details of all other Insurance covers/Claims

Policy No.	Name of the Insurance Company	Basic Sum Assured (SA)	Risk Commencement Date (RCD)	Claim Status <small>Please tick the appropriate boxes</small>					
				Claim Applied	Claim Not Applied	Partial Claim Amount Received	Legal Appeal filed against the claim	Full Claim Amount Received	Claim Denied
			D D M M Y Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (INR)	<input type="checkbox"/>	<input type="checkbox"/> (INR)	<input type="checkbox"/>
			D D M M Y Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (INR)	<input type="checkbox"/>	<input type="checkbox"/> (INR)	<input type="checkbox"/>
			D D M M Y Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (INR)	<input type="checkbox"/>	<input type="checkbox"/> (INR)	<input type="checkbox"/>
			D D M M Y Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (INR)	<input type="checkbox"/>	<input type="checkbox"/> (INR)	<input type="checkbox"/>
			D D M M Y Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (INR)	<input type="checkbox"/>	<input type="checkbox"/> (INR)	<input type="checkbox"/>

If claim not applied with other insurer, why? _____

Details of Life Assured's Habits

Substance	Forms of Consumption	Quantity
Alcohol	<input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Whisky <input type="checkbox"/> Others (Please Specify) _____	Per day _____ ml/bottle
Tobacco	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Bidis <input type="checkbox"/> Chewing Tobacco	____ No. of sticks or packets
Drugs	<input type="checkbox"/> Ganja <input type="checkbox"/> Hashish <input type="checkbox"/> Heroin <input type="checkbox"/> Cocaine <input type="checkbox"/> Charas <input type="checkbox"/> Marijuan <input type="checkbox"/> Others	____ No. of sticks or packets

Were you required to be away from work due to this condition? Yes No

If yes, please provide with details of dates and duration of time off work: _____

Original Documents required

1. Disability Certificate issued by appropriate Authority
2. Copy of FIR
3. Leave records for past 6 months from the Employer
4. Copy of Hospital/ Clinic case paper and Treatment reports
5. Original Policy Document
6. Identity and Address Proof

List of valid Identity & Address Proofs (Please tick the document submitted)

Photo Identify Proof (any one)	Address proof (any one)
<input type="checkbox"/> PAN Card <input type="checkbox"/> Valid Passport <input type="checkbox"/> Voter ID Card	<input type="checkbox"/> Valid Passport
<input type="checkbox"/> Aadhaar Card* <input type="checkbox"/> Valid Driving License	<input type="checkbox"/> Voter ID Card
<input type="checkbox"/> Bank Passbook with stamped photograph (not more than 6 months old)	<input type="checkbox"/> Aadhaar Card*
<input type="checkbox"/> ID Card Issued by Central/State Govt. to employees	<input type="checkbox"/> Valid Driving License
<input type="checkbox"/> Any other Central/State Govt. issued ID	<input type="checkbox"/> Bank Passbook with stamped photograph (not more than 6 months old)

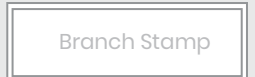
*I voluntarily provide my consent to use my Aadhaar to conduct identity check towards KYC compliance by HDFC Life

Customer Acknowledgement Copy (Accidental Total Permanent Disability Claim Form)

Policy No.: _____ Policyholder Name: _____

Customer Relations Officer: _____

Date: _____ Time: _____



Declaration & Authorisation:

I, _____, hereby declare that the statements made above are true and complete in each and every respect. I hereby authorise the hospital(s)/Doctor(s) who have examined or treated me for any ailment/illness, any laboratory where I may have undergone any investigation or tests; my employer(s), including any previous employer to provide information regarding the leave and medical assistance availed by me whether before or after the date mentioned in the form to furnish details of such ailments/illness and examination, treatment, investigation or test to the HDFC Life Insurance Company Limited or such persons or agency as may be authorised by the Company. I further authorise any government agencies including police and revenue to provide information and records that may be needed by HDFC Life to process the Claim. I agree to provide and furnish any other information/reports if required by HDFC Life for processing the claim.

Date: DD/MM/YYYY Place: _____

SIGN HERE

Signature of Policyholder 1

NOTE: The declaration below is to be completed where there is more than one Claimant.

I/We, _____ and _____ do hereby direct HDFC Life to discharge the entire amount in favour of Mr./Mrs _____, being one of the Claimants under the Policy.

SIGN HERE

Signature of Policyholder 2
(In case of Joint life)

Date: DD/MM/YYYY Place: _____

Declaration made by third person where the Policyholder has affixed his/her thumb impression/has signed in vernacular:

The Policyholder has affixed his/her thumb impression/has signed in vernacular/has not filled the application. I hereby declare that the content of this application form has been explained to the Policyholder in _____ language and have truthfully recorded the answers provided to me. I further declare that the Policyholder has signed/affixed his/her thumb impression in my presence.

Name of the Declarant: _____

Address: _____

Date: DD/MM/YYYY Place: _____

SIGN HERE

Signature of Third Person

NOTE

With reference to recent regulatory changes, please submit PAN or Form 60 (if you do not have a PAN) with HDFC Life with immediate effect. Please update via My Account/service@hdfclife.com/022-68446530/HDFC Life branch. Ignore if submitted.

HDFC Life Insurance Company Limited (HDFC Life). CIN: L65110MH2000PLC128245. IRDAI Registration No. 101.

Regd. Off: 13th Floor, Lodha Excelus, Apollo Mills Compound, NM. Joshi Marg, Mahalaxmi, Mumbai-400011.