LIFE INSURANCE

Aditya Birla Sun Life Insurance Company Limited

PROTECTING INVESTING FINANCING ADVISING

CONTINUOUS DISABILITY STATEMENT

All the information is to be filled in BLOCK LETTERS ONLY

Policy No.: ☐☐☐☐☐☐☐☐☐

Name of the Life Insured: ☐☐

To Be Completed By The Insured:

1. a) Are you still unable to follow your main occupation? Yes ☐ No ☐
   b) If "yes", when do you expect to return to work? ____________________
   c) If "no", please give details of all occupations that you are following ____________________
   ____

2. a) Are you able to perform some or all of your normal duties in carrying out your main occupation? Yes ☐ No ☐
   b) If "yes", please state details ____________________
   ____
   c) If "no", when do you expect to follow any occupation? ____________________
   ____

3. a) State name of medical practitioner last consulted ____________________
   Address: ____________________
   ____________________ Contact: ____________________
   b) When did you consult him? ____________________
   c) For what reason? ____________________

4. a) If you are receiving, or if you expect to receive any benefit because of your disability from any employer, any other insurance company, a pension fund, any State fund or from any source, please give particulars:

SOURCE OF BENEFIT	AMOUNT OF BENEFIT	DATE OF COMMENCEMENT OF PAYMENT

   b) Apart from any benefit mentioned above, please give details of any income which you have received, may have become entitled to receive or are still receiving during your disability and the reason for its payment to you.

SOURCE OF BENEFIT	AMOUNT OF BENEFIT	DATE OF COMMENCEMENT OF PAYMENT

5 (a) Are you aware or have you been advised of any material change in the circumstances of your disability since the date of your original Claim Form? Yes ☐ No ☐ If "yes" please give details
____

6. Remarks: ____________________
____

Declaration

I do hereby declare and warrant that the answers given by me in this Statement are in every respect true and correct and that no material information has been withheld nor any relevant circumstances omitted. I hereby provide my consent to receive call from Aditya Birla Sun Life Insurance Company Limited (ABSLI) or its authorized Service Providers in connection with any matter related to my above Policy.

Signature of Life Insured: __________ Date: D D M M Y Y Y Y Place: __________

Witness Name: ____________________ Witness Signature: __________

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