

iii) Operating Surgeon

D	D	M	M	Y	Y	Y	Y
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6. Particulars of Hospital/Medical Centre where admitted:

(i) Name: _____

(ii) Address: _____

(iii) Tel.No.

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(iv) Date of Admission:

D	D	M	M	Y	Y	Y	Y
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Operation _____

Discharge _____

7. Please submit the relevant reports

**Electronic Funds Transfer (EFT) Mandate Form
(Direct Transfer of funds to your bank account)**

Account Holder Name: _____

(as mentioned in Bank Account)

Bank name: _____

Type of Bank Account: _____

Bank Account Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Branch Address: _____

MICR code:

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(9 digit code as appearing on the cheque copy issued by bank)

IFSC code (Indian Financial Security code):

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Note:

Please attach Pre Printed Cancelled Cheque bearing the above mentioned Account Number and IFSC Code along with this form. In case of non-availability of Pre Printed Cheque, ABSLI requires a bank statement or a Printed Bankers Authorization in original containing aforesaid details duly seal and signed by Bank Branch Manager
In case of submission of incomplete / incorrect form Company will not transfer the Claim Proceeds Electronically and provide an account payee cheque mentioning account number and bank name if provided in the mandate or else company will draw an account payee cheque in case of admissibility of claim.

Declaration:

I / We hereby

- Declare that the details provided as above are correct and complete.
- Authorize ABSLI to process the proceeds under the claim of the aforesaid policy/s through EFT to the above mentioned account details
- Agree to not hold Aditya Birla Sun Life Insurance Company Limited or its associate / agent responsible in case of any non-credit to my bank account or if the transaction is delayed or not effected at all for reasons of error/ misrepresentation/incomplete/incorrect information furnished by me in this EFT mandate.

Date:

D	D	M	M	Y	Y	Y	Y
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Signature and stamp

Declaration by Group Policyholder:

We agree to save and hold Aditya Birla Sun Life Insurance Company Limited (ABSLI) harmless and indemnified against any and/or all losses, claims, liabilities, legal proceedings (including attorney fees'), expenses, or damages suffered by or taken against ABSLI arising on account of any error or misrepresentation in the information furnished for Electronic Fund Transfer which may be instituted, preferred, claimed or made against ABSLI, its successors or assigns by any person or persons making a claim to the said Policy benefits. We hereby declare that the particulars given above are true and correct. We undertake to indemnify Aditya Birla Sun Life Insurance Company Limited (ABSLI) the loss suffered, if any, due to wrong statement or information given in connection with this claim. We agree that submission of this form will not be construed as acceptance of the claim by ABSLI. ABSLI reserves the right to call upon additional documents. We agree that from this statement and all other papers and declarations in connection with this claim called by Aditya Birla Sun Life Insurance Company Limited (ABSLI) shall constitute Proof of Terminal Illness of the Member and may be used in any court of law. We agree that payment of claim amount shall constitute discharge of liability of ABSLI.

Name and Designation of the Authorized Person: _____

Signature of Authorized Person

Seal /Stamp of Group Policyholder

Date:

D	D	M	M	Y	Y	Y	Y
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Place: _____

Declaration by Life Insured:

I hereby notify the Aditya Birla Sun Life Insurance Co. Ltd. that Mr./Ms./Master _____ whose life was insured by the said company, under group policy no. _____ is/was suffering from the above mentioned disease/condition and hereby declare that the said person is the Life Insured described above and that the aforesaid answers and statements made by me are true and correct. I agree that furnishing of this form, or any forms supplemental thereto, shall not constitute nor be considered an admission of claim by Aditya Birla Sun Life Insurance Co. Ltd. that there was any assurance in force on the life in question or of its liability thereunder, nor a waiver of any of its rights or defense. I hereby authorize any physician, hospital, clinic, insurance company or other organization, institution or person, that has any record of the Member/ Life Insured or his health, to give to Aditya Birla Sun Life Insurance Company Limited, any and all information about the Member/ Life Insured reference to his health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. I further authorize the Employers (past and present) of the Life Insured to furnish to Aditya Birla Sun Life Insurance Company Limited, details of the leave availed of by the Life Insured during the last three years of his service together with copies of the leave applications and medical certificates, if any, submitted by the Life Insured in support of such applications and details of reimbursement of medical expenses. I also consent to a personal investigation. I agree that payment of claim amount shall constitute discharge of liability of ABSLI.

Signature of Life Insured (Member)

Date:

D	D	M	M	Y	Y	Y	Y
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Place: _____

FOR/1/17-18/1397

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