



Application Form For Dread Disease / Critical Illness Benefit Claim - (Form-AA)

Notes/Guidelines:

- This form is to be filled in by the person legally entitled for the policy money. All the answers must be clear & unambiguous.
- The benefit is payable subject to policy being in force on the date of event and also subject to fulfillment of all conditions/definitions as stated in the policy.
- Submission of this form should not be construed as acceptance of claim.
- Speedy and complete submission of documents would enable the company to expedite the claim processing.

Policy No:

Contact No of Life Assured:

I. Information about the Life Assured

| | |
|--|--|
| 1 a) Name of the Life Assured. | b) Complete Mailing Address..... |
| c) Age at Claim..... | |
| 2. Bank Details (Mandatory)- Name as per Bank Records..... Bank Name and Branch :.....Bank Account No: MICR Code.....IFSC Code..... (It is advisable to submit cancelled cheque for cross verification of bank details) | |

II. Information about the Dread Disease / Critical Illness

1.Claim submitted for (please tick any one of the below)-

| | | | |
|---|------------------------------------|--|---|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Coma |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Major Organ Transplant |
| <input type="checkbox"/> Coronary Artery Bypass Graft Surgery (CABGS) | | <input type="checkbox"/> Heart Valve Replacement or Repair | |

2. Exact Diagnosis.....
 3. Date of Diagnosis / Surgery.....
 4. Date of First Consultation.....

III. Information about the Doctors consulted and Hospitals from where treatment was taken

| S.No | Name of Doctor/ Hospital | Contact Number | Date of First Consultation | Treatment taken |
|------|--------------------------|----------------|----------------------------|-----------------|
| | | | | |
| | | | | |
| | | | | |

b) Name of Family Doctor.....Contact Number.....



Max New York Life Insurance Company Ltd.

11th & 12th Floor, DLF Square Building, Jacaranda Marg, DLF Phase II, Gurgaon 122 001.
Phone 2561717 (From Delhi +95124, other cities +0124)

IV. Declaration And Authorization

I..... do hereby declare that the statements made herein above are true and complete in all respects.

Notwithstanding any law, custom or convention, 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. I hereby authorize any doctor, physician or hospital who has attended upon or examined or treated me for any ailment or illness to divulge any knowledge or information regarding my state of health which he / they may have acquired whether before or after the policy was issued by the Company, to the MAX NEW YORK LIFE INSURANCE COMPANY LTD., any of its offices, or Court of Law.

Signed at..... (Place) on this.....Day of.Month.....Year.

Signature of Life Assured.....

Signature of Witness- Mandatory

| |
|--------------------------------|
| Signature : |
| Name : |
| Address :..... |
| |
| |
| Phone No (With Std Code) |

The form must be **witnessed** by any one of the following:
 (1) An Agent (2) Sales Manager / Branch Manager of the company (3) Block Development officer (4) A Bank Manager of a Nationalized bank with Rubber Stamp (5) An officer of the Company not below the rank of Manager (6) A Gazetted Officer (7) A Head Master / Principal of a Govt. School (8) A Magistrate.

Declaration in case of an illiterate Claimant where his/her left thumbs impression should be made by a person of standing unconnected with the company and whose identity can be easily established.

“ I hereby certify that the contents of above form are explained by me in the Language understood by the Claimant and that he/she has affixed his/her thumb impression to this form after fully understanding the contents thereof.”

(Full Signature of the Witness)

Name of Agent Advisor / CRO:..... Agent / CRO Code:

Name of Sales Manager :..... SM Code:.....

V. Please submit the following documents along with this Form:

1. Attending Physician Statement –Form-DD
2. All Consultation notes/Prescriptions in connection with the Dread Disease/Critical Illness.
3. Admission & History Sheet and Discharge Summary from the treating Hospital(s).
4. All Test Reports such as Biopsy report, ECGs, Cardiac Enzyme reports, blood tests, neurological tests, surgery notes.

NOTICE: Any person who knowingly files a claim containing false or misleading information, or who conceals information with intent to defraud or mislead the Company or other person, may be guilty of felony or subject to other criminal and/or civil penalties as the case may be under the applicable law(s) of the State.