

IV. Previous Claim History (Applicable in case of Wellness Plus Policy only)

S.No	Date of Claim	Illness and Diagnosis	Claimed Amount	Received Amount

V. Declaration and Authorization

I/We, the above-named claimant(s), do solemnly declare that the above answers and statements are true in all respects, and further agree that the furnishing of this form, or any other form supplemental thereto, to the Company, shall not constitute an admission by the Company that there was any insurance in force on the life in question or a waiver of any rights or defence.

Notwithstanding, any law, custom or usage, prohibiting the furnishing of secret information obtained during the medical treatment / investigation of Life Insured, I/We hereby authorize any doctor or other person, or any hospital, sanatorium, medical professional, hospital or other medical care institution, insurance support organization, pharmacy, governmental agency, insurance company, employer, benefit plan administrator, accountant, or financial adviser or other institute to provide to MAX LIFE INSURANCE COMPANY LTD., any of its offices, or Court of Law, or any investigative agency or independent administrator acting on its behalf, information concerning employment, finances or insurance, advice, care or treatment provided to Insured, or any information that may be required concerning the health of the Insured (Life Insured) including information relating to mental illness, use of drugs, use of alcohol, HIV(AIDS Virus) and /or sexually transmitted diseases. A Photostat copy of this authorization shall be considered as effective and valid as the original.

Signature of Life Insured.....
 Signed at (Place)..... Date.....

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)

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.

VI. Documents to be submitted along with this form

- 1.Attending Physician's Statement (Form WD).
- 2.Medical Records with dates- Admission notes, Discharge Summary/Card, Procedure /Surgery notes, all medical test reports, prescriptions, consultation notes, previous medical records and other insurance documents
3. FIR/Police Report/ Panchnama/ Inquest Report (only in case of accident)
4. Copy of driving license (only in case of Road Traffic Accident)

NEFT- Mandate Form

(To be filled in by the Applicant in BLOCK LETTERS)

I..... Nominee/ Policyholder of Policy Number.....
in the name of.....
here by request Max Life Insurance Co. Ltd. to make Claim payments directly to my bank account as per detail given below.

Particulars of Bank Account:

A/C Holder's Name: _____

Type of Bank Account: (Choose (√) any one) Savings A/C Current A/C

Bank Name _____

Bank Account No: -

IFS Code (11--digit unique alphanumeric code

as mentioned on your bank cheque book)

Bank Branch Address: _____

Mobile Number

Email id:

Declaration: I agree to save and hold Max Life Insurance Company Limited harmless and indemnified against any and/or all losses, claims, liabilities, legal proceedings (including attorney fees'), expenses, or damages suffered by or taken against Max Life Insurance Company Limited arising on account of any error or misrepresentation in the information furnished in this EFT mandate by me.

.....
Nominee/ Policyholder's Signature:

Date:

Bank Verification:

I, the undersigned authorized person, on behalf of the above mentioned bank, confirm that the bank account details of the individual as mentioned in this NEFT Mandate form are correct and are hereby verified.

Name of the Signing authority.....

Name of Bank:

Bank verification Stamp with branch address

.....
Signature of Authorized Signatory

Note: Please attach a copy of cancelled cheque bearing the above mentioned account number along with this form.