

**EFU LIFE ASSURANCE LTD**  
**LIVING BENEFIT CLAIM INTIMATION FORM**

**Section 1: Details of Policy**

|                                |                                |                 |
|--------------------------------|--------------------------------|-----------------|
| 1. Policy Number _____         | 2. Date of Commencement _____  | 3. Mode _____   |
| 4. Main Plan Sum Assured _____ | 5. Total Premium _____         | 6. Status _____ |
| 7. Riders _____                | 8. Next Premium Due Date _____ |                 |

**Section 2: Details of Life Assured**

|                                                        |  |  |
|--------------------------------------------------------|--|--|
| 1. Name _____                                          |  |  |
| 2. Correspondence Address _____                        |  |  |
| 3. Tel # _____ 4. Cell # _____ 5. E-mail Address _____ |  |  |

**Section 3: Details of Claim**

Tick on the appropriate benefit / rider under which the claim is being made:

|                                                                        |                                                                                     |
|------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| 1. Lifecare Benefit (LBI/LBP/LCI/LCP) <input type="checkbox"/>         | 4. Medical Recovery Benefit (MRB) <input type="checkbox"/>                          |
| 2. Accidental Disability Benefit (ADDB /ADDP) <input type="checkbox"/> | 5. Hospitalcare Benefit (HC+) <input type="checkbox"/> (No. of days admitted _____) |
| 3. Waiver of Premium Benefit (WOP) <input type="checkbox"/>            | 6. Accident and Sickness Benefit (AH/ASI/ADI) <input type="checkbox"/>              |

*Please check from the policy schedule that the benefit/rider is attached to the policy under which the claim is being made.*

**Section 4: Details of Event**

|                                                                                                                   |                                      |
|-------------------------------------------------------------------------------------------------------------------|--------------------------------------|
| 1. Type of illness/disability _____<br>(Name the event relating to the benefit/rider selected above in section 3) |                                      |
| 2. Place of accident (if accidental) _____                                                                        | 3. Date of occurrence of event _____ |
| 4. Date of first consultation with doctor or hospitalization (if any) _____                                       |                                      |
| 5. Name of the Hospital(s)/Clinic(s)/Doctor(s) consulted within last 1 year _____                                 |                                      |
| 6. Address, Tel. No. of Hospital(s)/Clinic(s)/Doctor(s) consulted within last 1 year _____                        |                                      |
| 7. Brief description of event (attach separate sheet of paper if required) _____                                  |                                      |

**Section 5 : Affirmation by the Life Assured\***

*\*Signature required in case this form has been filled out by the life assured, otherwise please leave blank.*

**I have fully understood the contents of this form and hereby declare that whatever is stated above is true and accurate to the best of my knowledge and belief.**

Signature of life assured \_\_\_\_\_ Date \_\_\_\_\_

*Disclaimer: Please note that this is an intimation of a living benefit claim and not in any way admission of liability on part of the Company. Separate detailed living benefit claim forms will be issued after submission of Intimation Form.*

**Section 6: Details of Branch Certification (To be filled by the Location Manager (LM))**

|                                          |                               |                   |
|------------------------------------------|-------------------------------|-------------------|
| 1. Branch Name _____                     | 2. Servicing Consultant _____ | 3. S.C Code _____ |
| 3. Date and time of intimation _____     | 3. Source of Intimation _____ |                   |
| 4. Any other important information _____ |                               |                   |
| 5. Name of Location Manager _____        | 6. Signature of LM _____      |                   |