LCF MRP003

CLM No.

HNB Assurance PLC (Reg.No.PQ 108)
Head office : 3rd floor, Iceland Business center, No 30.Sri Uttarananda Mawatha, Colombo - 03.
Telephone 011 2421885-7 Fax 4724513

TOTAL & PERMANENT DISABILITY CLAIM FORM

To be completed by the claimant (The Manager of the Bank) in BLOCK letters.

Please answer all questions, use "not applicable" (N/A) as appropriate instead of leaving it blank. Counter-sign where amendments/alterations are made in the form.
The filing of this claim form is not to be construed as an admission of liabilities of our Company. No agent has been or is authorized to admit any liabilities on behalf of the Company.

Policy No/Certificate No.:	Name of Insured: I/D No:	Age: Sex:	This is a ☐ New Claim ☐ Further Claim
Insured Email Address: Insured Mailing Address:		Contact Phone No. : Insured Whatsapp No :	

EMPLOYMENT PARTICULARS:

1. Occupation (if more than one, state all) and exact nature of occupational duties before disability	1.
2. Name and address of business or employer	2.
3. Did She / he file a sick leave certificate with the employer?	3. ☐ Yes ☐ No
4. Date she / he last worked:	4. _____ DD _____ MM _____ YYYY
5. Date she / he returned to work. (If no, then give expected date of return)	5. _____ DD _____ MM _____ YYYY
6. Do Insured currently engage or have Insured any intention to engage in political activities? (if yes, please specify the relationship) **Yes.** ☐ **No.** ☐	

PLEASE COMPLETE IF DISABILITY WAS DUE TO ACCIDENT:

7a. Date , time and location of accident:	7a. _____ DD _____ MM _____ YYYY _____am/pm at _____ city
b. Where and how did it happen?	7b.
c. Part of body injured and type of injury.	7c

PLEASE COMPLETE IF DISABILITY WAS DUE TO ILLNESS:

8a. Indicate the illness and give a brief description of symptoms.	8a.
b. How long had he/she been having these symptoms	8b.
c. Give details of consultation. i) The doctor first consulted for this illness. ii) The doctor who referred the insured to hospital. iii) Doctors seen for any similar condition in the past.	8c. Date Name(s) and Address(es) of Doctor(s)/Hospital(s) i) ii) iii)

9. DETAILS OF PHYCICIAN(S) CONSULTED OR HOSPITAL(S) ADMITTED FOR CURRENT DISABILITY

Name(s)	Address(es)	Admission/Patient No. (s)	Admission Date(s)
a)			
b)			
c)			

10 Life insurance amount covered by other companies: ***(To be completed by family member)***

Name of Company	Policy No.	Effective Date or Coverage Commencement Date	Amount Insured
1)_____	_____	_____	_____
2)_____	_____	_____	_____
3)_____	_____	_____	_____

LOAN DETAILS

(18) (i) Has the Loan Fully released ?

if **"Yes"** the date of release;

- **(Please, attached the Loan repayment schedule)**

(ii) Date of last repayment made

(iii) Moratorium given Yes ☐ No ☐

if **"Yes"** mention the given moratorium period : ……

(19) Outstanding loan amount at the time of death. -

i) Capital outstanding - Rs. ……

Ii) Interest outstanding _ Rs. ……

(20) **Branch account details for claim payments.**

Account Name : ……..…… Bank Name : ……

Branch Name : ……..…… Account Number : ……

Declaration :

I/We hereby declare that for the purpose of processing, managing this claim, and addressing any matters related to my/our insurance coverage, I/We authorize HNB Assurance PLC to collect, use, and share my/our personal and medical information with relevant medical professionals, institutions, or other entities involved in the process of settling this claim. This includes, but is not limited to, details of medical consultations, treatments, surgeries, hospital admissions, and hospital confinements related to health conditions.

I/We further authorize the release and exchange of information from any physicians, medical practitioners, hospitals, clinics, healthcare facilities, insurance or reinsurance companies, consumer agencies, or insurance support organizations as required to facilitate the processing of this claim.

Additionally, I/We consent to HNB Assurance PLC verifying my/our National Identity Card (NIC) details with the Department of Registration of Persons (DRP), as deemed necessary for the administration and management of my/our policy and claims.

I/We understand and agree that all personal and sensitive information will be handled by HNB Assurance in accordance with applicable data protection laws, including the Personal Data Protection Act No. 9 of 2022, and the privacy policies of HNB Assurance PLC.

Witness Signature _____ Claimant Signature _____

(Bank Manager)

Date _____ Date _____

Name of Witness _____ Name of Claimant _____

(Bank Manager)

(in block letters, family name first) (in block letters, family name first)

(Official Rubber Stamp)

HNB Assurance PLC is licensed by the Insurance Regulatory Commission of Sri Lanka (IRCSL)