JyotiLife

Shanta Plaza, Gyaneshwor, Kathmandu Nepal
P.O. Box No. 19433, Tel 4445941

AMR/AWI CLAIM FORM
GPA

THIS SECTION TO BE COMPLETED BY INSURED (बीमितले भर्नुपर्ने)

1. Policy No. (बीमालेख नं.) .....
2. Name of Insured (बीमितको नाम) .....
3. Date of Accident (दुर्घटना भएको मिति) ..... or Date of Sickness वा (बिरामी भएको मिति) .....
4. Nature of Disability (अशक्तताको प्रकृति) .....
5. Medical History of Disability (अशक्तता सम्बन्धि चिकित्सकिय विवरण) .....
6. Have you ever has same or similar condition previously? (के तपाईको यस अघि यस्तो वा यससँग मिल्दो जुल्दो अवस्था भएको थियो?) ☐ No थिएन ☐ Yes थियो Date (बिरामी भएको मिति) .....

Authorization (अधिकार प्रदान)

"The undersigned hereby authorizes all physicians, hospitals, clinics, Pharmacists, Laboratories, Employers, Insurance Companies, other Companies, Institutions or any other persons who have any records or information about me to provide Jyoti Life Insurance Company any and all information with respect to my health and medical history, consultations, medical prescription, treatments or complete copy of my hospital medical record. A photographic copy of this authorization shall be as valid as the original". I also authorize the company to deposit the payable claim amount in my below mentioned bank account.

मैले, म र मेरो स्वास्थ्य/उपचारसंग सम्बन्धित कुनैपनि जानकारी वा अभिलेख भएका सम्पूर्ण चिकित्सकहरु, अस्पतालहरु, औषधालयहरु, औषधि वितरकहरु, प्रयोगशालाहरु, रोजगारदाताहरु, बीमा कम्पनीहरु, अन्य संस्थाहरु वा अरु कुनै व्यक्तिलाई ज्योति लाईफ इन्स्योरेन्स कम्पनीलाई उक्त जानकारी तथा अभिलेख उपलब्ध गराउन अधिकार प्रदान गर्दछु ।

भुक्तानी हुने दावी रकम मेरो तल उल्लेखित बैंक खातामा जम्मा गर्न ज्योति लाईफ इन्स्योरेन्स कम्पनीलाइ अधिकार प्रदान गर्दछु ।

Insured's Signature (बीमितको हस्ताक्षर) ..... Date (मिति) ..... Contact No. सम्पर्क नं.) .....

Bank Name (बैंकको नाम) ..... Branch (शाखा) ..... Account No. (खाता नं.) .....

- Please submit treatment related documents and original bills along with this form.
  कृपया उपचारसंग सम्बन्धित कागजात तथा सक्कल बीलहरु यो फारमसंग पेश गर्नु होला ।
- Please submit the physician's statement overleaf if you do not have detailed prescriptions and treatment related papers from the doctor/hospital.
  पर्याप्त उपचारका कागजातहरु (प्रेस्क्रिप्सन, एक्स रे तथा ल्याब रिपोर्ट आदि) पेश हुन आएमा चिकित्सकको बयान फारम भर्न आवश्यक हुनेछैन ।

EMPLOYER'S STATEMENT (रोजगारदाताले भर्नुपर्ने)

1. Name and Address of Insured's Employer
   बीमितको रोजगारदाताको नाम र ठेगाना .....
2. Full Name of the Insured
   बीमितको पूरा नाम .....
3. When was Insured compelled to give up his duties? (Exact Date)
   दुर्घटना पछि बीमितले कहिले देखि आफ्नो कार्य छोड्न बाध्य हुनुभयो? (मिति खुलाउनुहोस्) .....
4. When did Insured return to work? (Exact Date)
   बीमितले कहिले देखि आफ्नो काममा फर्कनु भयो? (मिति खुलाउनुहोस्) .....
5. Was Insured's Injury the sole cause of his absence from duty for all of the above period? If not, give particulars
   के बीमित चोटपटकको कारणले गर्दा नै माथि उल्लेखित समयको लागि काममा उपस्थित हुन नसकेको हो? होइन भने विवरण खुलाउनुहोस् .....

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SIGNATURE (हस्ताक्षर) .....

NAME (नाम) .....

DESIGNATION (पद) .....

DATE (मिति) ..... COMPANY STAMP (कार्यालयको छाप) .....

PHYSICIAN'S STATEMENT

Name of Patient..... Age …… Gender ☐Male ☐Female

1. Nature of Disability.....
(Describe complications, if any)
If due to Pregnancy, what was the approximate date of inception? .....

2. a) Nature of Medical History of Disability ……

b) Cause of disability: i) ☐ Due to Accident Date of Accident ……

ii) ☐ Due to Sickness Date of Accident ……

3. Has patient ever had same or similar condition? ☐ Yes ☐ No

If "Yes" state when and describe……..

……

4. Describe full nature of Surgical (or Obstetrical) Procedure……

……

Date performed……..... Where performed……..

5. Date of Treatment : Office ……....

Visit Charge …….

Home ……

Visit Charge …….

6. Is further operation procedure or treatment anticipated? ☐ Yes ☐ No

If "Yes", explain……

……

PHYSICIAN'S NAME ……

NMC No. ……

ADDRESS……

DATE ……

SIGNATURE…… STAMP ……