



LOSS OF JOB

Name of the Insured

Designation  Responsibility

Date of Joining the Organization           Date of Termination / Suspension

Cause of termination / suspension

Name & Address of employer

City  State  Pin

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by HDFC ERGO General Insurance, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

I hereby declare that the particulars furnished above are true and correct to the best of my knowledge.

Place

Date

SIGN

# HDFC ERGO General Insurance Company Limited

## Consent for Mode of Claim Payment



Name of Insured

Policy Number

Claim Number

Beneficiary Name

Mode of Payment Cheque  Fund Transfer   
(Please tick for mode of payment)

(All Fields are Mandatory in case of Fund Transfer)

Insured's Name as per Bank Account

Bank Account Number

Branch Name

IFSC Code

Email address

Attachments In Support of Bank Details  
(Please tick the type of proof submitted) Cancelled Cheque  Bank Passbook Copy

Declaration: I Mr. / Mrs / Ms. ....  
undersigned, legal beneficiary of the above claim, declare that all details mentioned in this form are true and I agree to the mode of payment against the particular claim number mentioned above.

Signature of Beneficiary

Stamp Required in case of Company

Date