SuryaJyoti Life Insurance Company Limited
Head Office - Shanta Plaza, Gyaneshwor, Kathmandu Nepal
Tel 4545947/48/50, P.O. Box No. 19433, Email: info@suryajyoti.com

THIS SECTION TO BE COMPLETED BY INSURED (बीमितले भर्नुपर्ने)

1. Policy No. (बिमालेख नं.) .....

2. Name & address of Insured (बीमितको नाम, थर र ठेगाना).....
.....

3. Date of Accident (दुर्घटना भएको मिति) ..... or Date of Sickness वा (बिरामी भएको मिति) .....

4. Place of Accident (दुर्घटना भएको ठाउँ) .....

5. Nature of Disability (अशक्तताको प्रकृति) .....

6. Medical History of Disability (अशक्तता सम्बन्धि चिकित्सकिय विवरण) .....
.....

7. 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) .....

8. Name and address of attending physician/hospital (उपचारमा संलग्न चिकित्सक/अस्पतालको नाम, ठेगाना) .....

१. ..... २. .....

३. ..... ४. .....

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 SuryaJyoti Life Insurance Company any and all information with respect to my health and medical history, consultations, medical prescription, treatments or complet e 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 सूर्यज्योति 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.) .....

Witness Signature (साक्षीको हस्ताक्षर) ..... Date (मिति) ..... Contact No. सम्पर्क नं.) .....

- Please submit treatment related documents along with this form.
  कृपया उपचारसंग सम्बन्धित कागजातहरु यो फारमसंग पेश गर्नु होला ।

PHYSICIAN'S STATEMENT (उपचारमा संलग्न चिकित्सकले भर्नुपर्ने)

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 ……

   i) ☐ Permanent Disability ii) ☐ Temporary Disability or, iii) ☐ Can't be determined (as of now)

   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 ……