

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. 2. Name of Insured
(बीमालेख नं.) (बीमितको नाम, थर)

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

4. Place of Accident
(दुर्घटना भएको ठाउँ)

5. Nature of Disability
(अशक्तताको प्रकृति)

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

7. Have you ever has same or similar condition previously? No थिएन
(के तपाईंको यस अधियस्तो वा यससँग मिल्दो जुल्दो अवस्था भएको थियो?) Yes थियो Date (विरामी 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 complete a 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 सूर्योज्योति 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 कम्पनीलाई अधिकार प्रदान गर्दछु।

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