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

3. Name of Proposer (प्रस्तावको 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? ☐ No थिएन

(के तपाईको यस अघि यस्तो वा यससँग मिल्दो जुल्दो अवस्था भएको थियो?) ☐ 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 SuryaJyoti 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 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.) .....

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

PHYSICIAN'S STATEMENT (उपचारमा संलग्न चिकित्सकल भर्नुपर्ने)

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

1. Nature of Disability.....

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. Diagnosed date of Disability: ……..…….……

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

If "Yes", explain……..

……..……

7. Describe the present condition of patient……..

……..……..

8. For how long the patient has been suffering from Disability……..

PHYSICIAN'S NAME ……

NMC No. ……

ADDRESS……

DATE ……

SIGNATURE…… STAMP ……..……