Shanta Life Insurance PLC
Shanta Western Tower, Level 10
186, Bir Uttam Mir Shawkat Sarak
Tejgaon I/A, Dhaka 1208, Bangladesh
info@shantalife.com

PPD And PTD Claim Form

This form must be filled out by the policyholder

Insurance Types : ☐ Individual ☐ Group ☐ Others : _____

Policy No. / Member ID : _____ Policy Start Date : _____

Organizations Name : (**if Group/Bancassurance**) _____

Name of Insured/Claimant : _____

Date of Birth : _____ Mobile Number : _____

Address : _____

Bank Account Name : _____ Bank Name : _____

Branch Name : _____ Account Number : _____

Routing Number : _____

(Please attach a copy of cheque leaf)

Illness Background

Leave/Absence History of Sickness : _____

Start Date of Absence : _____ Date of Rejoining : _____

I, the undersigned, hereby grant my full authorization to all physicians, hospitals, clinics, pharmacies, laboratories, employers, institutions, and any other relevant parties, to release to Shanta Life Insurance PLC all information pertaining to my medical history, consultations, prescriptions, treatments, and copies of any hospital or medical records related to my care. Furthermore, I acknowledge that any copy of this authorization shall be considered as valid and binding as the original.

_____ _____

Signature of Insured/Claimant Date

_____ _____

Signature of Authorized Person (Group/Bancassurance) Date & Seal

Please submit all treatment documents such as prescription, investigations reports- blood, Urine, X-ray, ECG, Ultrasonogram etc., discharge certificate of insured illness.

To be completed by respective specialized physician and/or any physician who was involved in the treatment process (MO, RP, RS etc.)

Name of Patient : _____ Date of Birth : _____ Age : _____ (years)

01. Has the disability resulted from an accident? (give ✓) ☐ Yes ☐ No

If "Yes" please describe in details :

(a) Accident : _____ (b) Nature of Injury : _____

(c) Hospitalization(s) and Date(s) : _____

02. Is the disability caused by a medical condition? (give ✓) ☐ Yes ☐ No

If "Yes" please describe in details :

(a) Type of Disability : _____ (b) Date of Diagnosis : _____

(c) Hospitalization(s) and Date(s) : _____

(d) Treatment Details : _____

_____

03. Is the disability caused by any sickness? (give ✓) ☐ Yes ☐ No

If "Yes" please describe in details :

_____

_____

_____ _____

Name of Physician Mobile Number

_____ _____

BMDC Reg. No Address

_____ _____

Signature of Physician and Date Official Seal