Death Intimation cum Claim Form

EXIDE Life Insurance

Note: Please complete the form in CAPITAL LETTERS. **All fields with (*) are mandatory**

Claim form to be filled and duly signed by the nominee, assignee or Legal heir. In case of pension plans, to be filled by the spouse, if living. Submission of this form does not mean acceptance of Claim.

Note: This Claim Form needs to be witnessed by any of the following (1) Police Sub-Inspector (2) Bank Manager (3) Doctor (4) A Gazetted Officer (5) School Headmaster (6) Head Post Master/Departmental Sub-Post Master (7) Branch Manager of our Company (8) Block Departmental Officer (9) Tahsildar

All the photocopied documents submitted must be attested by any of the officials mentioned in the above Witness List.

POLICY NUMBERS

Policy Number*: Policy Holder's Name*:

Additional Policy Nos. : _____

LIFE ASSURED DETAILS

Name of Life Assured*:

Father's Name*:

Age at Date of Death*:

ID Proof Enclosed*: ☐ Aadhar ☐ PAN Card ☐ Voter ID ☐ Driving License ☐ Others, Specify: _____

CLAIMANT DETAILS

Name of Claimant*:

Address*:

City*: State*: PIN*:

Mobile* (Validated): Alternate:

E-mail*:

Relationship with Life Assured*: Age of Claimant:

Legal Status*: ☐ Policy Holder ☐ Nominee ☐ Assignee ☐ Others, Specify: _____

ID Proof Enclosed*: ☐ Aadhar ☐ PAN Card ☐ Voter ID ☐ Driving License ☐ Others, Specify: _____

Preferred Language of Communication*:

BANK ACCOUNT DETAILS

Bank Name*:

Bank A/c No.:

Bank Branch*:

IFSC Code*: 9 Digit MICR No.*:

Account Type*: ☐ Savings ☐ Current ☐ Cash Credit/Over Draft

Bank Account Proof Enclosed*: ☐ Cancelled Cheque ☐ Bank Statement ☐ Others, Specify: _____

Note: Cancelled Cheque with nominee signature / Bank Statement with transactions not later than last 3 months

OCCUPATION DETAILS

Last Employer/Business Name*:

Official Address*:

Designation*: Last Working Day*:

Exact Work at Job*:

Employer Mobile*: Other Phone Number:

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Continue filling the form overleaf. This form is considered "Private" when completed.

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LIFE ASSURED DEATH AND OTHER INSURER'S DETAILS

Details of other Life Insurance / Medi-Claim Policies held by the Life Assured:

Insurance Company Name	Policy Number	Commencement Date	Sum Assured (₹)	Claim Status

Death Date*: D D M M Y Y Y Y Death Time*:

Exact cause of Death*:

Place of Death*: ☐ Home ☐ Hospital ☐ Workplace ☐ ☐ Others, Specify: _____

Date of Burial/Cremation*: D D M M Y Y Y Y Place of Burial / Cremation*:

Was Post Mortem done?*: ☐ Yes ☐ No

***Note: If Yes, please provide attested copy of Post Mortem report**

***For accidental/unnatural death, Post Mortem Report and FIR are mandatory**

Name and designation of person who declared death:

Address of the person who declared death:

Contact No.

Documents Enclosed*: ☐ FIR ☐ PMR ☐ PANCHNAMA ☐ BURIAL CERTIFICATE ☐ DEATH DECLARATION COPY

Others, Specify: _____

LIFE ASSURED DEATH AND OTHER INSURER

In case of death due to Illness

Illness diagnosed date: D D M M Y Y Y Y Any other past illness: ☐ Yes ☐ No Duration of Illness

Illness suffered from:

Attended Doctor's Name: Doctor's Contact No.

Doctor's Address:

Treatments Taken:

In case of Hospitalization:

Date of admission in Hospital: D D M M Y Y Y Y Admission No.

Hospital Name:

Hospital Address:

Note: Physician Statement and Medical documents (Discharge / Death summary, Test results, Admission notes, Outpatient consultation notes, etc.) are mandatory if death due to Illness/Hospitalization.

Documents Enclosed*: ☐ All first consultation Papers ☐ Last hospitalization documents ☐ Last Medical attended certificate

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PENSION PLANS

Note: Mandatory for Pension Plans

In case you are the spouse, please indicate how you would like to receive the benefits: Your Age 45 years and above

- To receive the entire Benefit Amount as Lump sum ☐
- To receive one-third of the Benefit Amount as lump sum and apply the balance for purchase of annuity ☐
- To apply the entire Benefit Amount for purchase of Annuity ☐

For purchase of Annuity

- From Exide Life Insurance Company Limited: Fill in the proposal form for purchase of annuity available at any of our branches and submit it along with the documents asked for in the proposal form ☐
- From other Companies: Specify the company in whose favor the cheque needs to be issued (The company name as it is should appear in the cheque) ☐

AUTHORIZATION

The above statements are true and correct to the best of my knowledge. Notwithstanding any laws or provisions in force regarding privacy of personal information, I also authorize Exide Life Insurance Company Limited and/or its representatives, agents to collect all information / records (including photocopies) which are relevant to process this claim from employers, hospitals, doctors and others. I further authorize the hospitals, clinics, doctors, and / or diagnostic centers, to disclose any information and provide photocopies of medical / hospital records regarding Life Assured's health and habits, which they may have come to know during their treatment of Life Assured. List of acceptable witness given in page 1

Signature of Claimant* **Signature of Witness***

Date*: D D M M Y Y Y Y Witness Name & Designation*: _____

Place*: _____ Witness Contact Number: _____

If the executant is illiterate and has affixed a thumb impression or is subscribing his/her signature in vernacular, then the translator shall execute the following declaration. Certified that the contents of this Claim Form read over and explained by me to Mr./Mrs./Ms._____ (insert name) in _____language and that he/she has affixed his/her signature/thumb impression thereto in my presence after thoroughly understanding the contents herein.

*Note: Mandatory if claimant affixed thumb impression/vernacular signature

Name*: _____ **Signature of translator***

Contact Number: _____ Date*: D D M M Y Y Y Y

FOR OFFICE USE ONLY

Customer Service Representative Name*: _____ **Signature*** _____

Date*: D D M M Y Y Y Y Branch*: _____ e Number*: _____

ACKNOWLEDGEMENT SLIP

***Note: This is to acknowledge the receipt of application for Death Intimation cum Claim Customer Service**

Policy No.*: _____ Date*: D D M M Y Y Y Y **Executive Signature:** _____

Documents submitted ☐

Claim form ☐ KYC of claimant and insured ☐ Policy Bond ☐ Bank account details ☐ Death certificate ☐ FIR and MLC copy ☐

Medical documents if any ☐ Any other documents to specify_____

Note: "The Company reserves the right to call for any other and/or additional documents or information,including documents/information, to the satisfaction of the Company, for processing of the claim".

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