Group Term/ Employee Deposit Linked Insurance - Claim Intimation Form

Policy Number: Date: DD MM YYYY

Type of Policy: □ Group Term □ Employee Deposit Linked Insurance

Type of Claim: □ Death □ Critical Illness □ Disability

Name of the Member	
Member ID	
Date of Birth	DD MM YYYY
Date & time of death/ Date of diagnosis of CI / Date of Disability	DD MM YYYY
Place of death (E.g. Address of hospital)	
Cause of claim (Please specify exact cause of death or exact medical condition of CI or exact reason for disability)	
Age of the Member at the time of happening of an event	
Last working date if applicable	

Details of leave taken one year prior to commencement of member's cover: -

From (Date)	To (Date)	Reasons for leave	Nature of illness (in case of leave on medical grounds)

If leave has been taken on medical grounds copies of leave applications and medical certificates produced by the Member must be attached herewith.

Cause of claim	Document required
Non Accidental Death	□ Copy of Death certificate issued by local authority
Accidental Death	□ Copy of Death certificate issued by local authority □ Copy of Post Mortem Report & copy of FIR
Critical Illness /Disability claim	□ Copy of Discharge card/ summary from the hospital/s where the member was treated/diagnosed □ Copy of all diagnostic test reports & other hospital/medical records □ Copy of FIR (only in case of disability claim)

Please provide the following details in case the claim payout cheque has to be issued in favour of the beneficiary:

Sr No	Beneficiary Name	Relationship	Share % of claim value
1			
2			
3			
4			
5			

Please provide bank A/C details of beneficiary (passbook/cancelled cheque copy with name printed on it) for payment.

Term Amount to be paid (Rs.) : Specify Name of Payee :

We are aware that ICICI Prudential has a right to call for further information/documents.

Advance Discharge Voucher:

We ..... (name of the Company) understand and agree that ICICI Prudential Life Insurance Company shall be discharged of all liabilities in relation to the above claim upon the payment of the Claim moneys in case of acceptance of the claim by the Company.

Please affix
Re. 1/- revenue

Stamp of the Company: across the stamp

Signature of the authorized signatory: _____

Name of the signatory: _____

Place: _____

Date : DD MM YYYY

Instructions:

1. Submission Methods: You can submit the form by any of these convenient methods:
   a. By email - Kindly submit the form to grouplife@iciciprulife.com from the official email id of the authorized signatory
   b. By Fax - Please fax the form to Group Service at fax no. 022 42050803/4205 0805038 8199
   c. By Courier - Please courier the form to Group Service Desk
      ICICI Prudential Life Insurance Co. Ltd.,
      Rani Sati Marg, Malad (E), Mumbai - 400 097
2. The claim cheque would be dispatched to the last address recorded by us
3. For any assistance please write to us at grouplife@iciciprulife.com
4. ICICI Prudential Life Insurance Company shall be discharged of all liabilities in relation to the above claim upon receipt of claim amount by the payee mentioned above.
5. Insurance is the subject matter of the solicitation
   COMP/DOC/Jul/2018/177/1423