

DEATH CLAIM INTIMATION CUM CLAIMANT'S STATEMENT

(Format : AO)

Guidelines / Notes:

1. Death benefit is payable subject to policy being inforce on date of death.
2. Only the person entitled to receive the policy monies under the Policy should fill & sign this form.
3. Submission of this form should not to be construed as acceptance of claim.
4. Please submit the form & the requirements at the nearest branch office or the address given below;
ICICI Prudential Life Insurance Company, Claims Department,
4th Floor, Stanrose House, Appasaheb Marathe Marg, Prabhadevi, Mumbai- 400 025.
5. Early and complete submission of requirements would enable the company to process the claim at the earliest.

Policy Number(s): _____

1. Details of the Life Assured:

Full Name:	Age at Death:
Last Residential Address:	Tel. No.:
City / Town:	Pin Code:
	State:

2. Details of the Claimant (person entitled to receive claim proceeds under the policy):

Full Name:	Date of Birth / Age:
Current Correspondence Address:	Tel. No.:
City / Town:	Pin Code:
	State:
Residential Status:	<input type="checkbox"/> Resident Indian <input type="checkbox"/> Non Resident Indian (NRI) <input type="checkbox"/> Other
If NRI, please state Country of Residence:	
Relationship with the Life Assured:	
Nature of title to the Policy monies:	<input type="checkbox"/> Proposer <input type="checkbox"/> Nominee <input type="checkbox"/> Assignee <input type="checkbox"/> Other
Please enclose a copy of Photo Identification proof (please tick whichever is applicable):	<input type="checkbox"/> Passport <input type="checkbox"/> Driving License <input type="checkbox"/> Company ID card <input type="checkbox"/> Election card <input type="checkbox"/> Credit Card with Photo <input type="checkbox"/> PAN Card <input type="checkbox"/> <input type="checkbox"/> Bank Pass book with Photo Club card <input type="checkbox"/> If Any Other, please specify

Requirements to be submitted alongwith this form.

For Zero Death Benefit (Pension plan) / Investment plans / Paid-Up Policies:	(Please Tick)
1. Original Policy Document	<input type="checkbox"/>
2. Copy of Death Certificate issued by Local Authority	<input type="checkbox"/>
For all other plans:	
1. Original Policy Document	<input type="checkbox"/>
2. Copy of Death Certificate issued by Local Authority	<input type="checkbox"/>
3. Copy of Medico legal cause of Death Certificate	<input type="checkbox"/>
4. Medical Records (admission notes, discharge summary, test reports etc.)	<input type="checkbox"/>
5. Post Mortem Report for accidental death	<input type="checkbox"/>
6. FIR / Panchnama / Inquest Report for accidental death	<input type="checkbox"/>
7. Copy of Driving License if Life Assured was driving vehicle at the time of accident (applicable only if "Accidental Death Benefit Rider" is opted)	<input type="checkbox"/>

Note: The Company reserves the right to call for additional requirements.

3a. Details of the Claim:

Date of Death:	
Cause of Death:	

(3b, 4 & 5 are not required to be filled for Zero Death Benefit (Pension plan) / Investment plan / Paid-Up policies):

3b. Other Details

Place of Death (specify the name and address of the hospital, wherever applicable):		
Name & Address of the Doctor who declared the death:		
City / Town:	Pin Code:	Tel No:
Date of Post Mortem examination:		
Date & Time of cremation / burial:		
Name & Address of hospital where Post Mortem examination was done:		
City / Town:	Pin Code:	Tel No:
Name & Address of Police Station where FIR has been lodged:		
City / Town:	Pin Code:	Tel No:
What do you understand to be the circumstances of the Life Assured's death?		

4. Medical History of the Life Assured:

Nature of illness / ailment:		
Duration of the illness / ailment (specify from – to dates):		
Name & Address of the doctor / hospital who diagnosed & treated the Life Assured:		
City / Town:	Pin code:	Tel No:
Name & Address of Life Assured's usual / family doctor:		
City / Town:	Pin code:	Tel No:

5. Employment Details:

Last employer's / business name:		
Address:		
City / Town:	Pin Code:	Tel No:
Designation at work place / business:		
Exact nature of job / business:		
Date of last working day:		

6. Particulars of other Life Insurance / Mediclaim policies held by the Life Assured:

Policy No.	1	2	3	4
Name of the company:				
Commencement date:				
Sum Assured:				
Riders opted:				
Status of the Claim:				

■ I, _____ do hereby declare that the above statements are true in each & every respect. I hereby authorize any medical attendant or doctor who had attended to the above named Life Assured or employer/business associate of the Life Assured to provide any information or details as to the state of health, habits and occupation of the deceased, to the Company, within his knowledge before or after the policy was issued.

■ In case of Zero Death benefit (Pension plan) / Investment plan / Paid-up policies, where the Policy document is not submitted to the company and where the total payment is not more than Rs.5,00,000/-, I, _____ hereby agree to indemnify the Company against all liabilities that the company may incur on account of any claim being made by any other person on the basis of possession of the Policy document or otherwise.

■ **For Pension Plans (if claimant is spouse of the deceased then), please mention if proceeds are to be paid in:**

Lumpsum Pension

Note: Claimant, if not spouse, would get claim proceeds only in lumpsum.

	Signature of the witness:
	Name of the witness:
	Relationship with the claimant:
(Signature / Thumb impression of Claimant)	
<u>Date:</u> <u>Place:</u>	<u>Date:</u> <u>Place:</u>
<u>Tel No.:</u>	<u>Tel No.:</u>

Authorization

(To be signed by the claimant)

To,

Life Insurance Policy Number(s): _____

I, Mr. / Ms. _____ (name), _____ (relation) of Mr. / Ms.

_____ (name of the Life Assured) hereby give my consent to M/s ICICI Prudential Insurance Co. Ltd., and / or its representative to obtain all employment / medical / hospital records / other records (including photocopies) / information pertaining to the treatment / occupation of the deceased.

Yours faithfully,

Signature of the Claimant

Date: