Group Term/ Employee Deposit Linked Insurance - Claim Intimation Form

ICICI PRUDENTIAL LIFE INSURANCE
We cover you. At every step in life.

Policy Number: ☐☐☐☐☐☐☐☐ (dd / mm / yyyy) : ☐☐ ☐☐ ☐☐☐☐

Name of the Company : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Type of Claim: Death / Critical Illness / Disability

Name of the member : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
First name Last name

Member ID : ☐☐☐☐☐☐☐☐

Date of Birth : ☐☐ ☐☐ ☐☐☐☐ (DD MM YYYY) Date of joining : ☐☐ ☐☐ ☐☐☐☐ (DD MM YYYY)

Date & time of death/Date of diagnosis of CI / Date of Disability : ☐☐ ☐☐ ☐☐☐☐ (DD MM YYYY) ☐☐ Hrs ☐☐ Min

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 : ☐☐ Years ☐☐ Months

Last working date if applicable : ☐☐ ☐☐ ☐☐☐☐ (DD MM YYYY)

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 / Murder / Suicide	❑ 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

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

Full Name of the Beneficiary : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
First name Last name

Relationship with deceased member : ☐☐☐☐☐☐☐☐☐☐☐☐

Payment Details:

Claim 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 Trust) 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 & sign across the stamp

Stamp of the Trust :

Signature of the authorized signatory

Name of the signatory: _____

Place : _____

Date : ☐☐ ☐☐ ☐☐☐☐ (DD MM YYYY)

Instructions :

- The claim cheque would be dispatched to the last address recorded by us.
- 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.

ICICI Prudential Life Insurance Company Ltd., Group Service Desk, 4th Floor, Stanrose House, Appasaheb Marathe Marg, Prabhadevi, Mumbai - 25.