

Death Intimation cum Claim Form

*(Claim form to be filled and duly signed by the nominee, assignee or Legal heir in **BLOCK LETTERS**. Please fill in complete & correct details. Attach all necessary documents. **Submission of this form does not mean acceptance of Claim**)*

Policy No.:

SECTION A: CLAIMANT DETAILS

1. **Name of Claimant:** _____
2. Current Address: _____

 _____ State: _____ Pin code: _____
 Phone No.: _____ Mobile No. _____
 E-mail ID of the claimant: _____
3. Relation-ship with Life Assured: _____ Age of Claimant: _____
4. Legal Status: Policyholder Nominee Assignee Others (please specify) _____
5. Photo Identification Proof Enclosed:
 Passport PAN Card Voter's Id Driving License Others (please specify) _____
6. Bank Account Details:
 Account Number: _____ Name of Bank: _____ Branch: _____
 Please attach a copy of your Bank passbook / copy of your bank statement as proof of above bank account

SECTION B: LIFE ASSURED DETAILS

1. **Name of Life Assured:** _____
2. Father's name: _____
3. Residential address of Life Assured at date of death: _____

4. Age at date of death: _____
5. Occupation particulars: Last Employer / Business Name: _____
 Address of Employer / Business: _____
 _____ Telephone: _____
 Designation: _____ Exact Nature of Job / Business: _____
 Last Working day: _____
6. Details of other life insurance / medi-claim policies held by the life assured:

| Name of Insurance Company | Policy Number | Commencement Date | Sum Assured | Status of Claim |
|---------------------------|---------------|-------------------|-------------|-----------------|
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7. Date of death: _____ Time of Death _____
8. Place of death: _____
9. Date of Burial / Cremation: _____ Place Buried / Cremated: _____
10. Cause of death: _____
11. Was a Post Mortem done, if yes, please provide attested copy of report: _____
12. Name and Address of Doctor who declared the death: _____
 _____ Pin Code: _____ Telephone No. _____
13. In case of accidental or unnatural death,
 Police station where FIR was registered: _____ FIR Number: _____ Date: _____
14. Clear narration of events leading to death:

15. In case, cause of death is illness
- a) Date on which the illness was first diagnosed: _____
- b) Duration of last illness: _____
- c) Other Illness suffered: _____ Duration: _____
- d) Name & Address of doctor who attended: _____

 Phone No.: _____ Mobile No. _____
- e) Particulars of treatment taken: _____

- f) If hospitalized
- i. Date of admission in hospital: _____
- ii. Admission Number: _____
- iii. Hospital Name & Address: _____

SECTION C: ATTACHMENTS TO THIS FORM (please tick):

- ⇒ Original Policy Document
- ⇒ Original Death Certificate issued by Local Authority
- ⇒ Age Proof & Identification document (with Photo) of Life Assured
- ⇒ Identification document (with Photo) of Claimant
- ⇒ Copy of Medical Cause of Death Certificate

- ⇒ Medical Records (Discharge / Death summary, Test results, Admission notes, Outpatient consultation notes, etc)
- ⇒ Attested Copy of Post Mortem Report
- ⇒ In case accident / unnatural death,
 Jurisdictional Police Station Attested Copy of FIR
 Jurisdictional Police Station Attested Copy of Panchnama /Inquest Report
- ⇒ Proof of Bank account of Claimant (Self Attested copy of Bank Passbook / Account statement of Claimant)
- ⇒ Proof of your Current Address

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

SECTION D: AUTHORIZATION BY CLAIMANT:

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 ING Vysya Life Insurance Company Ltd. 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 Assureds' health and habits, which they may have come to know during their treatment of Life Assured.

Place: _____

Signature of Claimant

Date: _____

Signature of Witness: _____

Name & Address of Witness: _____

Relationship with the Claimant _____

Phone No. with STD Code _____ Mobile No. _____

If the executant is illiterate or is subscribing his/her signature in vernacular, then the witnesses shall execute the following declaration

Certified that the contents of this Claim Form were 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.

Date: _____

Signature: _____

Name of Witness: _____

Address: _____

Contact Telephone: _____