CLAIMANT STATEMENT FORM (DEATH CLAIM):

FORM (A-1)

Edelweiss Tokio life
zindagi unlimited

Without prejudice

- The form needs to be completed by the beneficiary under the policy or by the legally entitled person
- Please ensure all questions are answered. Ensure use of "Not Applicable" (N/A) instead of leaving it blank
- Claim proceeds are payable as per terms & conditions mentioned in the policy document and subject to the policy being inforce as on the date of event/death
- Early & Complete submission of requirements would enable the Company to process claims at the earliest
- The company reserves the right to call for additional documents / requirements

Submission of ID proof of the claimant is mandatory along with this form

Policy No.: | | | | | | | | | | | | | | | |

Particulars	Details of the Life Assured	Details of the claimant
Name	Mr./Mrs./Master/Ms._____ _____	Mr./Mrs./Master/Ms._____ _____
Address	_____ _____ _____ _____	_____ _____ _____ _____
Tel. no.:		
Date of death	D D M M Y Y Y Y	NA
Cause of death		NA
Age at the time of death	_____ years	NA
Place of death	_____	NA
Relationship with Life Assured	NA	_____
In what capacity do you claim	NA	☐ Appointee ☐ Nominee ☐ Assignee ☐ Others

Details of the claim	
Name & address of the doctor who declared the death	_____ _____ _____
Date & time of cremation	D D M M Y Y Y Y Time: _____
Date of post mortem examination	D D M M Y Y Y Y
Name Address and contact no. of the hospital, where the Post-mortem examination was carried out	
In case of death due to accident, answer the following:	
• Name & address of the police station where FIR was lodged	_____ _____
• Date & Time of accident	D D M M Y Y Y Y
• Place of accident	_____
• Was the Life Assured driving at the time of accident	☐ Yes ☐ No

Previous Health/ Habit details of Life Assured

Nature of Illness / Habit	Please Select Yes/No		Duration (since when)	If Yes, Quantity Details
Hypertension	Y	N		NA
Diabetes	Y	N		NA
Heart disease	Y	N		NA
Kidney disease	Y	N		NA
Liver disease	Y	N		NA
Cancer	Y	N		NA
Any other ailments / disorder/ surgery/ hospitalisation in last 5 yrs	Y	N		NA
Any habits like smoking/ alcohol/ tobacco/ drugs (Please select)	Y	N		

Details of the Illness

Nature of the illness	_____			
Date of diagnosis	D D M M Y Y Y Y			
Treatment details	_____ _____			
Hospitalization details	• Name of the Hospital: _____ • Date of Admission: D D M M Y Y Y Y • Date of Discharge / Death: D D M M Y Y Y Y (Kindly submit the copy of the Discharge Summary or Death Summary along with this form)			
Duration of illness related to current illness	_____			
Details of hospitalisation expenses and mode of payment				
Details of amount claimed under Mediclaim/health insurance policy during last five years	Name of the Insurer	Sum Assured	Amount of claim received	Date of claim

Names & Address of physician/hospitals attended the deceased within the last 5 years preceding death

Name of the Physician/Hospital	Address	Date of First attendance	Disease or Illness

Other details of the Life Assured

Employment details	
Last Employer's / Business Name:	_____
Address	_____ _____
Designation at work place/business:	_____
Last working date:	D D M M Y Y Y Y
Annual income	_____
Nature of Job/ Business	_____
Family Physician details	
Name of the doctor	_____
Address & Tel. No.	_____ _____
Since when has been the Life Assured taking treatment from the doctor	_____
Name the illness for which treatment was taken	_____

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

Name of the Co./ TPA	Policy No.	Risk Commencement Date	Sum Assured	Claim Raised Yes/No	Status of Claim	Amount Claimed

Electronic Payout option (Direct transfer of funds in your bank A/c)

1. Name of the Bank A/c holder: _____
2. Bank Name: _____ Branch Name: _____
3. A/c No.: _____
4. A/c Type: ☐ Saving ☐ Current ☐ NRI ☐ NRO
5. IFSC code: _____ MICR Code: _____

☐ Cancelled cheque required along with this form

Payouts would be in accordance and subject to the terms and conditions of the policy. Further, the company reserves the right to use any alternative payout option including demand draft/payable at par cheque in spite of opting for Electronic payout method. I will not hold Edelweiss Tokio Life Insurance Company Ltd. responsible in case of non-credit to my bank account or if the transaction is delayed or not effected at all for reasons of incomplete/ incorrect information.

Signature / Thumb impression of the claimant: _____

Date: D D M M Y Y Y Y

Document enclosed with the said form

- ☐ Death certificate issued by municipal / local authority
- ☐ Medico legal cause of death certificate
- ☐ Copy of post mortem examination and police report
- ☐ Indoor medical records if life insured was hospitalized
- ☐ Copy of the receipt issued by Cremation ground, if any
- ☐ Specify any other document _____

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

Mr. / Ms. / Mrs. _____ (name of the Life Assured), do hereby declare and confirm that I am the rightful claimant of the deceased person and the above statements are true and complete in each & every respect.

In order to enable the company to assess the claim under this policy, I authorize the Company to procure documents/details from the

- Past and present employer (s) business associates
- Medical practitioner/ Hospitals (Govt/ Pvt.)
- Any life and non life insurance company

And hereby give my consent to the above authorities to release to the company, such details/documents which may be required during the assessment of the claim.

In case where the Policy document is not submitted to the Company, 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.

Yours Faithfully,

Signature / Thumb impression of the claimant	**Name & signature of the witness** Name: _____ Signature: _____ Relation with the claimant: _____
Telephone with STD code: _____	Telephone with STD code: _____
Place: _____	Place: _____
Date: _____	Date: _____