

Group Policy Number: _____

Certificate of Insurance No.: _____

Details of the Deceased

1) Name of the Deceased: <input type="text"/>	
2) Date of Birth: <input type="text"/> DD <input type="text"/> MM <input type="text"/> YYYY	
3) Place of Death: _____	4) Date of Death: <input type="text"/> DD <input type="text"/> MM <input type="text"/> YYYY
5) Cause of Death: _____	
6) Name, Address & Tel. No. of doctor/ hospital certifying death:	Name: _____
	Address: _____
	Tel. No. : <input type="text"/>

Details of the Affinity

Name of the Affinity Group: <input type="text"/>
Address: <input type="text"/>
Tel. no.: <input type="text"/>

Details of the Nominee

Name of the Nominee: <input type="text"/>	Date of Birth Nominee: <input type="text"/> DD <input type="text"/> MM <input type="text"/> YYYY
Address: <input type="text"/>	
Tel. no.: <input type="text"/>	
Whether nominee is a <input type="checkbox"/> Minor <input type="checkbox"/> Major	
If Minor,	
Name of the Appointee: <input type="text"/>	Date of Birth Appointee: <input type="text"/> DD <input type="text"/> MM <input type="text"/> YYYY
Address: <input type="text"/>	
Tel. no.: <input type="text"/>	
Relationship with nominee: <input type="text"/>	

Please note: Copy of Photo ID and Address Proof of the appointee is to be attached with the said documents.

In case of Accidental death please provide the details for the following

a) Name & address of the police station where FIR was lodged: _____
b) Date & Time of accident: <input type="text"/> DD <input type="text"/> MM <input type="text"/> YYYY Time: _____
c) Place of Accident: _____
d) Date of Post mortem examination: <input type="text"/> DD <input type="text"/> MM <input type="text"/> YYYY
e) Was the Member driving at the time of accident: <input type="checkbox"/> Yes <input type="checkbox"/> No

In case of Non Accidental death please provide the details for the following

a) Nature of Illness: _____
b) Date of Diagnosis: DD MM YYYY
c) If Hospitalized then: Name of the Hospital: _____ Date of Admission: DD MM YYYY Date of Discharge/Death: DD MM YYYY
d) Name & Address of the Physician who attended the deceased at the time of death: Name : _____ Address: _____ _____

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: <input type="checkbox"/> Saving <input type="checkbox"/> Current <input type="checkbox"/> NRI <input type="checkbox"/> NRO	
5. IFSC code: _____ MICR Code: _____	
<input type="checkbox"/> Personalised 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.	
Date: DD MM YYYY	Signature / Thumb impression of the claimant: _____

Declaration

I/We _____ do hereby declare that this statement made herein above are true in each and every respect.	
I/We agree to provide and furnish details and reports as and when required by Edelweiss Tokio Life Insurance Co. Ltd. for processing this claim.	
Declared at: _____	
Signature: _____	
Name in Block Letters: _____	
Address: _____	

Telephone number: _____	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>
Date: _____	
Stamp / Seal of the Master Policy holder	