CLAIMANT STATEMENT FORM (DEATH CLAIM):
FORM (A-1)

Edelweiss Tokio life
Insurance se badhkar hai ***aapki zaroorat***

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: ________________________________