STAR UNION DAI-ICHI LIFE INSURANCE CO. LTD.

# CLAIMANT'S STATEMENT – FORM A Date :_____

( Answers to all questions be filled legibly. Answers to all queries be given in words only. )

## CLAIM FOR: 1. DEATH / 2. CRITICAL ILLNESS / 3. DISMEMBERMENT

1) Policy Number : _____ , _____
2) Name of the Life Assured : _____
3) Date of Birth of Life Assured : _____
4) Occupation of the Life Assured : _____
5) Date of death : _____
6) Place of death : _____
7) Time of death :_____ am / pm
8) Cause of Death : _____
9) If death due to accident : Date of Accident : _____
10) Was death reported to police : Yes / No, (If yes, attach copy of FIR).
11) Was post-mortem done : Yes / No, ( If yes, attach a copy of post-mortem Report)
12) Name of the Claimant : _____
13) Name of the Nominee : _____
14) Relationship with the deceased Life Assured : _____
15) Address of the Claimant / Nominee : _____
: _____
: _____
Contact No. (Mandatory): _____
16) Date of Birth of the claimant / nominee : _____
17) If the claimant / nominee is a minor,
Appointee name : _____
18) I wish to commute 1/3rd of the Fund value or Sum Assured to be paid to me in Lumpsum and 2/3rd of the Fund Value or Sum Assured should be drawn in favour of SUD Life Insurance Co. Ltd. OR_____
(Please write name of the Insurance company from where you want to purchase annuity) as full and final settlement. **(Applicable for Dhruv Tara & New Dhruv Tara Plan Only)**



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19) Particulars of other Life Insurance / Mediclaim Policies held by the Life Assured

| Name of the Company | Policy No. | Risk Commencement Date | Sum Assured | Claim Raised (Yes/ No) | Cause of Claim |
|---|---|---|---|---|---|
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| | | | | | |

Bank Account Details of the Nominee: (Please attach a cancelled cheque)

Bank Name: _____ Branch Name _____

Bank Account Number: _____

Nominee name as per Account Number: _____

Bank Account Type: Savings ☐ Current ☐

IFSC Code: _____ MICR Code:_____

I, _____, hereby declare that the answers given above are true in all respect. Notwithstanding the provisions of any law, I hereby authorize the company to contact any Physician or Hospital to enquire about the health of the deceased, who treated him / her in the last illness of the deceased. I will not hold Star Union Dai-ichi Life Insurance Company Ltd. responsible in cases of non-credit to my bank account or if the transaction is delayed or not effected at all for reasons of incomplete/ incorrect information.

IMPORTANT : I am enclosing herewith the death certificate of Mr./ Ms. _____ duly attested by Mr. _____.

_____

Signature / thumb impression of claimant / nominee

_____

Signature of witness

Name of witness : _____

Designation : _____

Address of witness : _____

_____

Contact No : _____



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Certified that the contents in this form were explained in detail to the declarant in the language : _____ and this form is filled in as per dictation given by him / her.

Place : _____ _____

Date : _____ Signature of witness

Name : _____

Address : _____

_____

**(The person signing as witness on this claimants statement should be : 1) Lawyer, 2) Specified person of Banks / AVP / Bancassurance Manager of SUD Life Ins. CO. Ltd., 3) Bank Branch Manager, 4) Block Development Officer, 5) Commissioner of Oaths , 6) Family Physician, 7) Govt. Gazetted Officer, 8) Head Master / Head Mistress, 9) Head Post Master, 10) Magistrate, 11) Sarpanch / Police patil. The person witnessing the form should not be related to the deceased in any manner).**



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