



SHRIRAM

Life Insurance

YOUR PARTNER FOR PROSPERITY

associated with  Sanlam group

DEATH CLAIM FORM "A"

Divisional office:.....

Branch Office:.....

***Mere Submission of Claim with Documents does not assure admission of liability.**

Please read the INSTRUCTIONS mentioned below before filling up form.

Instructions

- All fields are mandatory.
- The claimant should be the person as nominated by the life assured.
- The payments shall be subject to the terms and conditions of the policy.
- The company retains the right to call for additional evidence to process the claim.
- All alterations/corrections made, need to be countersigned by the claimant.
- If the Insured died outside India and was cremated or buried abroad, please provide burial/cremation permit along with names and addresses of two people not related to the deceased, present at the burial/cremation.

In connection with Claim under Policy No. _____ for Sum Insured of Rs. _____
 on the life of _____ I, _____
 the claimant under the Policy make the following statement.

Particulars of Insured:

Policy No (s):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Deceased Name in Full: _____ _____	Date of Birth: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Age at Death <input type="text"/> <input type="text"/> Years
Marital Status at time of death: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Last Occupation/Main Duties: _____ _____
Residential Address: _____ _____ _____	Telephone with STD Code: _____ Mobile No.: _____
Name of Employer:	
Present Occupation:	
Address: _____ _____ _____	Telephone with STD Code: _____ Mobile No.: _____

Details of Death:

Type of Death:

Medical Accidental Non-Accidental Suicide Murder Others

Exact cause of death: _____

Age at Death: Date of Death: Time of Death

Place of Death:

Hospital/Clinic Residence Office Others please specify.....

Name & Address of the Doctor who declared the death: _____

City: _____ Pin Code: State: _____ Telephone with STD code: _____

Name & Address of Police Station where FIR was lodged (if any) _____

Name of the Doctor who conducted the PM _____

City: _____ Pin Code: State: _____ Telephone with STD code: _____

Claimant Details:

Name:

First Name

Middle Name

Surname

Relationship with the Life Assured: _____

Date of Birth: Gender: Male Female

Title under which claim is made (Tick whichever is applicable)

Nominee Appointee (in case claimant is a minor) Survivor Trustee Assignee HUF

Address: _____

Mobile No.:

Telephone with STD code:

Claimant Bank Details:

Payout Option: Cheque NEFT

ELECTRONIC PAYOUT OPTION: (Direct transfer of funds to your bank account). Please submit Bank passbook copy/statement attested by the Bank branch manager with seal.

Name of Nominee/Claimant:

Bank & Branch Name:

Account No.: IFSC Code:

Declaration: I/We authorize Shriram Life Insurance Company Limited to process the proceeds under the death claim of the aforesaid policy/s through Electronic Funds Transfer to the above mentioned bank account details. I/We, accept the full responsibility for above mentioned Bank account details. I/We will not hold Shriram Life Insurance Company Limited liable for any loss if funds are transferred or not transferred or delayed due incomplete or incorrect or third party banking details provided above.

Signature / Thumb Impression of the Claimant: _____

Payment Option Details (As per product feature):

Lump Sum Installment

