Life Insurance

(To be completed by the Group Policy Holder)

Aditya Birla Sun Life Insurance Company Limited



PROTECTING INVESTING FINANCING ADVISING

Aditya Birla Payment Bank - Death Claim Form

Group Policy No.:	Name of GPH: Aditya Birla Payment B	Bank		
Full Name of deceased Member:		Member Id:		
Date of Birth:	Y Date of Joining Policy: D D M M Y Y Y			
Date of Death:	Time of death: H H M M A.M / P.M.			
Cause of Death:		Age as on date of death: Years Month(s)		
In case of accidental death: Date of	Accident: D D M M Y Y Y Y Nature of Acciden	nt: Road/Rail/Air/Other (specify)		
Upon admissibility of Claim, the Paymer	nt to be made in favour of Beneficiary. Beneficiary 1	Beneficiary 2		
If Payment to be made in favour of Beneficiary then please provide the below details.	Beneficiary 1 Beneficiary 2			
Beneficiary Name :				
Bank Name :				
Relation with Member:				
Type of Bank :				
Account No :				
IFSC Code :				
Contact No:				
Email id :				
Declaration by Group Policyholder:				
liabilities, legal proceedings (including misrepresentation in the information f successors or assigns by any person ma undertake to indemnify Aditya Birla Sun in connection with this claim. We agree Life Insurance Company Limited (ABSLI)	attorney fees'), expenses, or damages suffered by or trumished for Electronic Fund Transfer which may be in king a claim to the said policy benefits. We hereby declar Life Insurance Company Limited (ABSLI) from the loss suit that this statement and all other papers and declaration of shall constitute Proof of death and may be used in any of the large that submission of this form will not be constituted.	is and indemnified against any and/or all losses, claims taken against ABSLI arising on account of any error or instituted, preferred, claimed or made against ABSLI, its re that the particulars given above are true and correct. We ffered, if any, due to wrong statement or information giver as in connection with this claim called by Aditya Birla Surcourt of law. We agree that payment of claim amount shall trued as acceptance of the claim by ABSLI. ABSLI reserves		
Name and Designation of the Authorized	d Person:			
Signature of Authorized Person:				
Seal/Stamp of Group Policy holder	Date:	Place:		
Declaration by Claimant:				
hereby notify the Aditya Rirla Sun Life	Insurance Company Limited (ARSLI) that Mr / Ms / Mast	er whose life was insured by the said		

certificates, if any, submitted by the Life insured	in support of such applications	and details of reimbursement (medicai expenses.	i also consent to a
personal investigation.				
I agree that payment of claim amount shall cons	titute discharge of liability of ABS	·LI.		
Date: D D M M Y Y Y Y	Signed at		Signature of Claimar	nt

- a) Copy of Death Certificate issued by Municipal Authority/Gram Panchyat duly attested by the Group Policyholder.
- b) Death Claim Form.
- Bank statement/Printed Cancel Cheque Copy. c)
- d) KYC of Beneficiary.

In case of Unnatural death

Copies of FIR, Post Mortem Report, Police Inquest Report attested by the Group policy holder would be required to be submitted. ABSLI reserves the right to call for any additional requirements/Information to process the Claim.

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Medical Attendant's Certificate (Group Death Claim)

Group Policy No.: Member Id:						
Name of Group Policyholder:						
Full Name of deceased Member:						
Date of Death: D D M M Y Y Y Y Time of Death: H H M M A.M / P.M. Place of Death:						
Cause of Death: (a) Immediate (b) Primary Age: Years Month(s)						
1. Are you the patient's regular attending physician? Yes No						
If Yes, since how long had you been acquainted with the deceased?						
2. When and for what illness did you treat the patient in the past?						
3. Date on which you first attended the patient for the present illness						
4. State exact duration of last illness prior to death						
5. a) Was the deceased hospitalized during his illness? Yes No						
b) If yes, kindly fill in the details of the patient as per hospital records?						
Name of the Hospital:						
Address of the Hospital:						
Admission Date: D D M M Y Y Y Y Discharge date: D D M M Y Y Y Y Y IP NO						
6. Was a Post Mortem examination conducted? Yes No , if yes, please provide details.						
Name of the Doctor:						
Address:						
Contact Details: Mobile No.: Mobile No.:						
Registration No.: E-mail Id:						
Declaration:						
I/We hereby certify that the above information is true and correct as per the records maintained by me/hospitals. I hereby provide my consent to receive call from Aditya Birla Sun Life Insurance Company Limited (ABSLI) or its authorized Service Providers in connection with any matter related to this Policy.						
Any confidential information, which in your opinion should be in the possession of the company, should be forwarded to Head Office at the below mentioned						
address						
Seal of the Doctor: Signed at On day of 20						