Life Insurance

(To be completed by the Group Policy Holder)

Aditya Birla Sun Life Insurance Company Limited



PROTECTING INVESTING FINANCING ADVISING

Idea Cellular Limited - Death Claim Form

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Group Policy No.:	Name of GPH: Idea	Cellular Limited								
Full Name of deceased Member:		Member Id:								
Date of Birth:	Date of Joining Policy: D	M M Y Y Y Y								
Date of Death:	Y Y Time of death: H H M M	A.M / P.M.								
Cause of Death:		Age as on date of d	leath: Years Month(s)							
In case of accidental death: Date of	Accident: D D M M Y Y Y Y	Nature of Accident: Road/Rail/Air/O	ther (specify)							
Upon admissibility of Claim, the Payme	nt to be made in favour of Beneficiary.	Beneficiary 1 Beneficiary	Beneficiary 3							
If Payment to be made in favour of Beneficiary then please provide the below details.	Beneficiary 1	Beneficiary 2	Beneficiary 3							
Beneficiary Name :										
Bank Name :										
Relation with Member:										
Type of Bank :										
Account No :										
IFSC Code :										
Contact No:										
Email id :										
Declaration by Group Policy Holder: We agree to save and hold Aditya Birla Sun Life Insurance Company Limited (ABSLI) harmless and indemnified against any and/or all losses, claims, liabilities, legal proceedings (Including attorney fees'), expenses, or damages suffered by or taken against ABSLI arising on account of any error or misrepresentation in the information furnished for Electronic Fund Transfer which may be instituted, preferred, claimed or made against ABSLI, its successors or assigns by any person or persons making a claim to the said Policy benefits. We hereby declare that the particulars given above are true and correct. We undertake to indemnify Aditya Birla Sun Life Insurance Company Limited (ABSLI) the loss suffered, if any, due to wrong statement or information given in connection with this claim. We agree that from this statement and all other papers and declarations in connection with this claim called by Aditya Birla Sun Life Insurance Company Limited (ABSLI) shall constitute Proof of death and may be used in any court of law. We agree that payment of claim amount shall constitute discharge of liability of ABSLI. We agree that submission of this form will not be construed as acceptance of the claim by ABSLI. ABSLI reserves the right to call upon additional documents. Name and Designation of the Authorized Person: Signature of Authorized Person:										
Seal/Stamp of Group Policy holder	Date: DDMM	Y Y Y Y Place:								
Declaration by Claimant:										
I hereby notify the Aditya Birla Sun Life	e Insurance Company Limited (ABSLI)	that Mr./Ms./Master	whose life was insured by							

the said company, under group policy no._______ is no more and I hereby declare that the said person is the Life Insured described above and that the aforesaid answers and statements made by me are true and correct. I agree that furnishing of this form, or any forms supplemental thereto, shall not constitute nor be considered an admission of claim by Aditya Birla Sun Life Insurance Company Limited (ABSLI) that there was any assurance in force on the life in question or of its liability thereunder, nor a waiver of any of its rights or defence. I hereby authorize any physician, hospital, clinic, insurance company or other organization, institution or person that has any record of the deceased or his health, to give to Aditya Birla Sun Life Insurance Company Limited (ABSLI), any and all information about the deceased with reference to his health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. I further authorize the Employers (past and present) of the Life Insured to furnish to Aditya Birla Sun Life Insurance Company Limited (ABSLI), details of the leave availed of by the Life Insured during the last three years of his service together with copies of the leave applications

and medical certificates, if any, submitted by the Life Insured in support of such applications and details of reimbursement of medical expenses. I also									
consent to a personal investigation. I agree that payment of claim amount shall constitute discharge of liability of ABSLI.									

Date:	D	D	М	М	Υ	Υ	Υ	Υ	Signed at	Signature of Claimant

Mandatory Documents required to be submitted with this claim form:

- Copy of Death Certificate issued by Municipal Authority/Gram Panchyat duly attested by the Group Policyholder.
- Death Claim Form. b)
- Bank statement/Printed Cancel Cheque Copy.
- 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 addition requirements/Information to process the Claim.

Life Insurance

Aditya Birla Sun Life Insurance Company Limited



PROTECTING INVESTING FINANCING ADVISING

Medical Attendant's Certificate (Group Death Claim)

Name of Group Policyholder: Full Name of deceased Member: Date of Death: (a) Immediate	Full Name of decessed Member: Date of Death: Date of Death:	Group Policy No.: Member Id:														
Date of Death: Down Yyy Y Time of Death: H M M AM / PM. 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 Difference of the Hospital: No Address of the Hospital: Address of the Hospital: No Discharge date: Dommy Yyy Y Discharge date: Dommy Yyy Y Discharge date: No , if yes, please provide details. Certified that the above information is correct as per the records maintained by me/hospital. Name of the Doctor: Address: Mobile No.: Mobile No.:	Date of Death:	Name of Group Policyholder:														
Cause of Death: (a) Immediate	Cause of Death: (a) Immediate	Full Name of deceased Member:														
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: DDMMYYYY Discharge date: DDMMYYYY IP NO. 6. Was a Post Mortem examination conducted? Yes No , if yes, please provide details. Certified that the above information is correct as per the records maintained by me/hospital. Name of the Doctor: Address: Contact Details: Mobile No.:	1. Are you the patient's regular attending physician? Yes No If Yes, since how long had you been acquainted with the deceased?	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:														
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	Seal of the Doctor: Signed at On day of 20	Seal of the Doctor:	_ Signed at	_ On c	day of 20	·										