

**BAJAJ ALLIANZ LIFE INSURANCE COMPANY LTD**  
GE Plaza, Airport Road Yerwada, Pune 411006

**DEATH CLAIM  
(CLAIMANT'S STATEMENT)**

**DOCUMENT'S CHECKLIST:**

a. Claimant's Statement	<input type="checkbox"/>	h. Consent letter duly signed	<input type="checkbox"/>
b. Medical Attendants Certificate	<input type="checkbox"/>	i. Original policy contract	<input type="checkbox"/>
c. Proof of age e.g. Passport No, birth cert	<input type="checkbox"/>	J. Employers Certificate	<input type="checkbox"/>
d. Death certificate duly certified	<input type="checkbox"/>	k. Newspaper cutting, if any	<input type="checkbox"/>
e. Post mortem report duly certified &	<input type="checkbox"/>	l. Hospital reports & investigation report	<input type="checkbox"/>
f. Police reports for accident/suicide	<input type="checkbox"/>		
g. Certificate of Hospital Treatment	<input type="checkbox"/>		
h. Burial / cremation Report	<input type="checkbox"/>		

All payments shall be made according to terms and conditions of the policy.

The company retains right to call for further evidence needed to process the claim and to entertain or repudiate the claim.

Acceptance of forms does not amount to admission of claim.

Duplicate copies must be attested by. 1. A Notary Public 2. A Block Development Officer 3 A Magistrate  
4. A Commissioner of Oaths 5. A class 1Gazetted officer 6. A Head postmaster 7. A Head master of a  
high school

Any one of the following must countersign this statement. 1. An agent of Bajaj Allianz Life Insurance  
Co.Ltd. 2 Unit Manager of Bajaj Allianz Life Insurance Co LTD 3. An Advocate 4. A Bank Manager 5. A  
Block Development Officer 6. A Commissioner of Oaths 7. A Gazetted officer 8. President of Village  
Panchayat 9. A Magistrate 10. A Head postmaster 11. A Head master of a high school

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**DEATH CLAIM  
(CLAIMANT'S STATEMENT)**

Agency/location/agents's code \_\_\_\_\_ Claim No: \_\_\_\_\_ (For Office use only)

This printed form is issued on receipt of notice of death claim and liability.  
To be completed by the nominee(s) or trustee(s) or assignee(s).  
Acceptance of forms does not amount to admission of claim.

**PART ONE**

**PARTICULARS OF INSURED:**

Policy No (s)	Age / Sex
Deceased Name in Full	Occupation / Main Duties
Marital Status at time of death <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Time of Death ( <b>mandatory</b> )
Residential Address	<b>Telephone No</b> (Res) (Mobile)
Name of Employer	
Present Occupation	
Address	<b>Telephone No</b> (Res) (Mobile)

**DETAIL OF DEATH:**

Date of death	Place of death (State location of death e.g. hospital/institute/home - state name of location & address)
Cause of death	
On what date did the deceased last attend to his / her usual work DD                      MM                      YY	

**IF THE DEATH WAS DUE TO ACCIDENT:**

Date of accident	Time of Accident
Details & place of Accident (Make a sketch of accident)+ Details of news paper reports ( if any)	
<b>Details of Eye Witness to Accident:</b>	
Name of Eye Witness:	Age/Sex
Address:	
Telephone No	
Describe briefly how it happened (in own words not more than 50, Sketching is permitted)	
FIR details (attach enclosures)	
PIR details (attach enclosures)	
Post mortem Report Details (attach enclosures)	

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**IF THE DEATH WAS DUE TO ILLNESS**

Nature of illness	
Immediate cause of death of life assured	
Symptoms	Duration of Symptoms

**Please give details of consultation(s)**

Consultation	Name (s)	Address	Contact No	Date	Disease/Condition	Diagnosis
a) The doctor 1 <sup>st</sup> consulted for this illness						
b) The doctor who referred the deceased to hospital for treatment						
c) All other doctors A) consulted for this /other illness B)						
d) Usual medical attendant/Family doctor						

**PRIOR ILLNESS**

Nature of the Pre-existing/ co-existing Disease/ Illness	Exact Duration of that disease/ Illness	Give All the Treatment Details	Doctor Details with address & contact no.

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**PART TWO**

**ABOUT THE POLICY REGARDING ASSIGNMENTS/ REASSIGNMENTS**

Name of person who is in possession of the policy \_\_\_\_\_

Is the Policy Assigned Yes  No   
 Is the Policy Reassigned? Yes  No

Name of the Assignee \_\_\_\_\_  
 Address of the Assignee \_\_\_\_\_

**GENERAL INFORMATION**

Details of Other Policies

Name of Companies/ Contact No / Address	Policy Dates	Policy No	Amount of Policies (Sum Insured)

**PART THREE**

**ABOUT THE CLAIMANT (S)**

Claimant Name in Full \_\_\_\_\_

In what Capacity do you Claim \_\_\_\_\_

Are you a major? Yes  No  If Yes, **state Age** \_\_\_\_\_ (Mandatory)

Relationship To the Deceased / Insured (Please tick ✓)

Parents  Siblings  Friends   
 Spouse  Children  Relatives

Colleagues  Employer  Others   
 (Please specify \_\_\_\_\_ )

Address of the Claimant \_\_\_\_\_  
 Contact No. of the Claimant \_\_\_\_\_ (Res) \_\_\_\_\_ (Off)

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**BANK DETAILS OF THE CLAIMANTS**

Name of Bank \_\_\_\_\_ Contact No. of Bank \_\_\_\_\_  
Account Number \_\_\_\_\_ Address of Bank \_\_\_\_\_

**DECLARATION**

I / We hereby make a claim to the said assurance with **BAJAJ ALLIANZ LIFE INSURANCE COMPANY LIMITED** and agree that the written statement of all the physicians who attended to or treated the deceased, and all papers furnished in support of this claim shall constitute and they are hereby made a part of the proofs of death and further agreed that the furnishing of this form or any other forms supplemental thereto or any acts of enquiry or investigation by the said Company shall not constitute or be considered an admission by the company that there was an assurance in force on the life in question nor a waiver of any of its rights or defences.

I/We affirm that we are aware that notwithstanding any provision of law/usage/custom or convention for the time being in force prohibiting any physician or hospital from developing any knowledge or information regarding the deceased assured on grounds of secrecy the company is authorized to seek such information and as the same had been consented by the deceased in his contract of insurance with the Company.

I / We hereby authorise any physician or other person or any hospital, sanitorium or other institution to furnish to **BAJAJ ALLIANZ LIFE INSURANCE COMPANY LIMITED**, any information that may be required concerning the late \_\_\_\_\_ and the photocopy of this authorisation shall be valid as original.

_____ Signature of Claimant 1 Name: Address:	_____ Signature of Claimant 2 Name: Address:	_____ Signature of Claimant 3 Name: Address:
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_____ Signature of Witness 1 Name: Address:	_____ Signature of Witness 2 Name: Address:	_____ Signature of Witness 3 Name: Address:
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Note: All claimants/class-1 legal heirs must sign at the space provided above