

Affix recent passport size colour photograph of claimant and sign across it (Not more than 6 months old)



INDIVIDUAL DEATH CLAIM FORM

SECTION A

POLICY DETAILS

Policy Number	
Name of Life Assured (Deceased):	

DETAILS OF DEATH OF THE LIFE ASSURED

Date of Death	D D M M Y Y Y Y	Time of Death	H H M M (AM/PM)
Address of Place of Death			
Date and Address of Burial / Cremation			
Cause of Death			

* If cause of death is due to Accident, provide date of Accident

D D M M Y Y Y Y

SECTION B

DETAILS OF DOCTOR / HOSPITAL / CLINIC CERTIFYING DEATH (To be filled in by the treating doctor / hospital)

Name of Treating Doctor			
Doctor Registration Number			
Name of Hospital and Clinic			
Address of Hospital and Clinic	C I T Y \ T O W N \ V I L L A G E		
	D I S T R I C T		
	S T A T E		
	C O U N T R Y		
Landline Number	STD Code		Mobile Number ()
			Country Code
Nature of Illness			
Treatment Given			
Duration of Treatment			

Signature & Stamp of Treating Doctor

DETAILS OF USUAL FAMILY DOCTOR (To be filled in by usual family doctor)

Name of Family Doctor			
Doctor Registration Number			
Address of Family Doctor	C I T Y \ T O W N \ V I L L A G E		
	D I S T R I C T		
	S T A T E		
	C O U N T R Y		
Landline Number	STD Code		Mobile Number ()
			Country Code
Nature of Illness			

Signature & Stamp of Family Doctor

SECTION C

OTHER INSURANCE/MEDICLAIM POLICY DETAILS OF LIFE ASSURED

Sr. No.	Name Of The Insurer	Policy Number	Sum Assured	Claim Status
1				Intimated / Non Intimated
2				Intimated / Non Intimated
3				Intimated / Non Intimated
4				Intimated / Non Intimated

• Please attach separate sheet, if insurance taken from more companies

EMPLOYER DETAILS OF THE LIFE ASSURED (Only for salaried person)

Name of Employer										
Contact Details	STD Code		HR Mobile Number ()		Country Code					
HR Email Id										
Designation of Life Assured										
Nature of duties	<input type="checkbox"/> Office Work	<input type="checkbox"/> Field Work	City Of Employment							

SECTION D

DETAILS OF CLAIMANT

Name of Claimant										
Appointee Name (If Claimant / Nominee is minor)										
Date of Birth of Claimant / Nominee / Appointee	D D M M Y Y Y Y									
Relation with Deceased (Life Assured)										
Occupation Details	<input type="checkbox"/> Service	<input type="checkbox"/> Business	<input type="checkbox"/> Self Employed	<input type="checkbox"/> Housewife	<input type="checkbox"/> Others					
Monthly Income (INR)	<input type="checkbox"/> Up to 25000	<input type="checkbox"/> 25000 - 50000	<input type="checkbox"/> 50000 - 100,000	<input type="checkbox"/> Above 100,000						
Address	C I T Y \ T O W N \ V I L L A G E									
	D I S T R I C T									
	S T A T E					C O U N T R Y				
	P I N C O D E									
Landline Number	STD Code		Mobile Number ()		Country Code					
Email Id										
1. Are you resident of jurisdiction outside India?	<input type="checkbox"/> Yes	<input type="checkbox"/> No								
2. Are you tax resident of jurisdiction outside India?	<input type="checkbox"/> Yes	<input type="checkbox"/> No								
3. Country of residence / tax residence										

(In case if the answer to any of the above question is Yes, the kindly submit FACTA CRS self-certification)

BANK ACCOUNT DETAILS OF CLAIMANT

Bank Name										
Branch										
IFSC (11 Character code appearing on your cheque leaf)										
Bank Account Number										
Account Holder Name (As per Account)										
Account Type	<input type="checkbox"/> Savings	<input type="checkbox"/> Current	<input type="checkbox"/> NRO	<input type="checkbox"/> NRE						

• For Bank Account proof, a cancelled personalised cheque with the account no. and IFSC should be submitted OR Copy of latest bank statement OR Copy of passbook (where name, account number and IFSC is printed) needs to be submitted.
 • For recently opened bank account, last 3 months statements is required

CLAIMANT'S DECLARATION

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. I confirm that I have read and understood the FATCA & CRS Terms and Conditions and hereby accept the same. I hereby confirm that the information provided above with respect to my residency/ tax residency is true and correct, and hereby agree that I am obliged to inform the Company about any change in such information till the processing of the claim. I/We agree that this information may be shared with domestic regulators/tax authorities/statutory authorities, including but not limited to the Financial Intelligence Unit-India (FIU-IND), the tax / revenue authorities in India or outside India wherever it is legally required and other investigation agencies without any obligation of advising me of the same.

Date
 Place _____

Signature / Thumb impression of the Claimant

DECLARATION TO BE MADE BY A THIRD PARTY (if the claimant has affixed thumb impression or signed in vernacular language)

I, Mr./Ms./Dr.	
Address	
	C I T Y \ T O W N \ V I L L A G E
	D I S T R I C T
	S T A T E C O U N T R Y P I N C O D E

Having known the claimant for a period of (____ Month ____ Year); do declare that I have explained the contents of this form to the claimant in his/her language and have truthfully recorded the answers provided by him/her. I further declare that the claimant has affixed his/her signature/thumb impression in my presence.

Signature / Thumb impression
of the Declarant

DOCUMENTS TO BE SUBMITTED

NATURAL DEATH	ACCIDENTAL DEATH
Original policy document <input type="checkbox"/> <i>(If policy document is lost, need Notarized Indemnity Bond on stamp paper of relevant currency)</i>	First Information Report (FIR) Panchnama / Inquest report, <input type="checkbox"/>
Death Certificate issued by local authority <input type="checkbox"/>	Post Mortem report (PMR), Viscera Report <input type="checkbox"/>
KYC documents and cancelled cheque / bank passbook of claimant* <input type="checkbox"/>	Newspaper cutting, Police final report, if required <input type="checkbox"/>
Claimant's passport size photograph <input type="checkbox"/>	Original policy document <input type="checkbox"/>
Employer certificate in case Life Assured was salaried <input type="checkbox"/>	<i>(If policy document is lost, need Notarized Indemnity Bond on stamp paper of relevant currency)</i>
HOSPITALISATION / DEATH DUE TO ILLNESS	Death Certificate issued by local authority <input type="checkbox"/>
Medical cause of death certificate <input type="checkbox"/>	KYC documents and cancelled cheque / bank passbook of claimant <input type="checkbox"/>
Medical records (Admission Notes, History / Progress Sheet, Discharge / Death Summary, Past Medical Records) <input type="checkbox"/>	Claimant's passport size photograph <input type="checkbox"/>
	Employer certificate in case Life Assured was salaried <input type="checkbox"/>

* In case of minor nominee, need KYC, Cancelled cheque leaf OR Copy of Bank Statement / Passbook of Appointee



Star Union Dai-ichi Life Insurance Co. Ltd.

Registered Office: 11th Floor, Vishwaroop IT Park, Plot No. 34, 35 & 38, Sector 30A of IIP, Vashi, Navi Mumbai - 400 703.
 Toll Free No.: 1800 266 8833 (8.00 am to 8.00 pm - Mon to Sat) • Board Line No.: 022-3954-6200 • Fax No.: 022-3947-2811.
 Email: claims@sudlife.in • Website: www.sudlife.in | IRDAI Regn. No. 142 • C.I.N.: U66010MH2007PLC174472
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Customer Acknowledgement Copy-Individual Death Claim Form

Policy Number		Name of Claimant	
Name of Life Assured		Date	D D M M Y Y Y Y
Branch Name			
Employee Name			
Employee Sign		Company Stamp	

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