

SURRENDER/PARTIAL WITHDRAWAL REQUEST FORM

PAGE | 2

IRDA REGN. NO. 142

The information on this form and to the best of my/our knowledge and belief the certification is true, correct and that the Company is relying on this information. I/We understand that the Company is not able to offer any tax advice on CRS/FATCA or its impact. I/We shall seek advice from professional tax advisor. I/We further agree to submit a new form within 30 days if any information or certification on this form becomes incorrect. I/We agree that as may be required by domestic regulators/tax authorities the Company may also be required to report, reportable details to CBDT or close or suspend my account.

Name of Policyholder: _____	Signature of Policyholder: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
Name of Witness: _____	Signature of Witness: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

Please affix
Re 1/-
revenue stamp
& sign across
the stamp

Declaration to be made if

Policyholder has affixed thumb impression OR Policyholder has signed in vernacular OR Policyholder has not filled the Application

I Mr./Ms./Dr. _____

Address _____

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

Date: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Signature of Declarant: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
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FOR OFFICE USE ONLY (Affix stamp in the box)

 Signature verified: YES NO

 Branch Date/Time Stamp
(Affix stamp in this box only)

Bank/Branch staff signature: _____

Branch Checklist:

- | | | |
|--|------------------------------|-----------------------------|
| Policy Document / Indemnity Bond: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancelled Cheque in original / Pass Book Copy (self attested): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Photo ID proof (self attested): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Address proof (self attested): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Customer Signature Verified: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Star Union Dai-ichi Life Insurance Company Limited
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 (9:00 am to 7:00 pm – Mon to Sat)

 Email: customercare@sudlife.in | Website: www.sudlife.in | IRDAI Regn. No. 142 | CIN: U66010MH2007PLC174472

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