kotak®
Life Insurance

A JOINT VENTURE WITH OLD MUTUAL

GROUP INSURANCE RIDER CLAIM FORM

COMPLETE IN DUPLICATE – RETAIN COPY FOR YOUR RECORDS
(All sections to be completed)

A. PLAN DETAILS

(1) **Name of Plan** _____ (2) **Policy Number** _____

(3) **Policy holder Name** _____

Address _____

Pin Code _____ **Phone Number** _____

B. MEMBER DETAILS

(1) **Name of Member** _____

(Title)	(Surname)	(First Name)	(Middle Name)

Residential Address _____

Pin Code _____ **Phone Number** _____

		DOB								
(2)	**Date of Birth**	D	D	M	M	Y	Y	(6)	**Member ID.**	
(3)	**Date of Joining**	D	D	M	M	Y	Y	(7)	**Category & Salary Grade**	
(4)	**Cover commenced date**	D	D	M	M	Y	Y	(8)	**Last Drawn PF based Salary**	
(5)	**Annual Salary**	D	D	M	M	Y	Y	(9)	**Cover Amount**	

C. DETAILS FOR GRATUITY AND SUPPERANNUATION CLAIMS

(1)	**Date of resignation**	D	D	M	M	Y	Y	(2)	**Date of retirement**	D	D	M	M	Y	Y	

D. CLAIM EVENT DETAILS (FOR ILLNESS CLAIMS ONLY)

(1)	**Date of Diagnosis of CI**	D	D	M	M	Y	Y	(2)	**Type**	Natural /Accidental / Suicide / Murder / Others*

(3) **Cause of Illness** _____

(4) **Place of treat with address**

E. ADDITIONAL DETAILS (FOR FAMILY BENEFIT CLAIMS OF INSURED FAMILY MEMBERS ONLY)

(1) **Name of the deceased** _____

(Title)	(Surname)	(First Name)	(Middle Name)

(2)	**Date of Birth**	D	D	M	M	Y	Y	(3) **Relationship to member**	

F. BENEFIT DETAILS

(1)	**Benefit Payable to**	❑ Policy holder	❑ Beneficiary**	❑ Member
(2)	**Benefit to be paid by**	❑ Cheque	❑ Electronic Fund Transfer	

(3) **Bank Account Details (mandatory)**

Name of Account Holder _____ Account No _____

Name of Bank and Branch _____

(4) **Address to which cheque and confirmation of payment should be sent:**

Contact Person _____

E-mail Address _____

Postal Address _____
_____

** Beneficiary details form to accompany this form

Remarks _____

_____

DECLARATION AND AUTHORITY TO PAY CLAIM

I/We the undersigned, in my/our capacity as (designation)……………………………………………………………..and duly authorised to make this declaration, hereby declare:

  i.   That the person whose resignation / retirement / death/Illness gave rise to this claim has in fact resigned / retired / died and was in fact a legitimate member of the Plan on the date of resignation / retirement / death /Illness.

  ii. That he/she joined employment / the Group on (date) …………….. and he/she was actively at work / in Good Health on the date of commencement of cover.

  iii. That in the event the claim is admitted, the payment of the proceeds due in respect of the above member in terms of the afore-mentioned Plan shall represent the full and final discharge of Kotak Mahindra Old Mutual Life Insurance Ltd's liability in respect of that member under the said Plan.

Signed at: ……………………………………………………………… this…………day of………………………… 20…..

OFFICIAL COMPANY STAMP	Designation …………………………………..
	Name ………………………………………
	Signature ………………………………....

Please attach to this form Primary documentation required for Death /Illness claims:

- Original death certificate issued by the Municipal Authority
- Last attending doctor's certificate stating the exact cause of death
- Proof of age (e.g. Birth Certificate, School leaving certificate etc.)
- Proof of membership (e.g. Certified copy of the latest Pay slip, certified copy of membership card etc)
- If death has occurred in a hospital, all case history papers.
- If the death is due to an accident or any other unnatural cause, we require
    - A certified copy of the FIR filed with the Police authorities
    - A certified copy of the Post Mortem Report/Autopsy Report
    - A certified copy of the Driving License if death occurred while driving
- Beneficiary nomination form if claim is payable to the beneficiary
- Proof of relationship with member (for family benefit claims only)

(The above mentioned documents are indicative and additional documents may be called for where necessary)

FOR Kotak Mahindra Old Mutual Life Insurance Ltd. OFFICE USE ONLY

I confirm that I have checked the details on this form and have satisfied myself that they are correct.

Name ……………………………………………………………

Designation ………………………………………………………..

Signature …………………………………………………………….