GROUP INSURANCE CLAIM FORM FOR CI CLAIMS

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** _____

(2)	**Date of Birth**	D D M M Y Y	(6)	**Member ID.**	
(3)	**Date of Joining**	D D M M Y Y	(7)	**Loan Amount**	
(4)	**Cover commenced date**	D D M M Y Y	(8)	**Annual salary**	
(5)		D D M M Y Y	(9)	**Cover Amount**	

C. CLAIM EVENT DETAILS (FOR DEATH CLAIMS ONLY)

(1) **Date of Diagnosis of CI** D D M M Y Y

(3) **Nature of CI** _____

(4) **Name of the Hospital where treatment was taken**

E. BENEFIT DETAILS

(1) **Benefit Payable to** ❑ **Policy holder** ❑ **Beneficiary**** ❑ **Member**

(2) **Bank Account Details (mandatory)**

Name of Account Holder _____ Account No _____

Name of Bank and Branch _____

(3) **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 illness gave rise to this claim is in fact ill and was in fact a legitimate member of the Plan on the date of diagnosis of the 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 Life Insurance Company 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 claims:

- Proof of membership (e.g. Certified copy of the latest Pay slip, certified copy of membership card etc)
- All case hospital papers & history papers.

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

FOR Kotak Mahindra Life Insurance Company 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 …….

Contact No ……

E-mail ID ……..

For any queries please write to the below Address : Claims Department | Kotak Mahindra Life Insurance Co Ltd, Building No 21, Infinity IT Park, Off Western Express Highway, Gen. A. K. Vaidya Marg, Malad (E), Mumbai - 400097.