

DEATH CLAIM INTIMATION FORM INDIVIDUAL POLICY CLAIMS

	Instruction for filling up the form	
AFFIX BRANCH	This claim intimation should be mandatorily accompanied by a valid claim event proof document.	Photograph of
SEAL	This claim shall be considered valid only on submission of a proper claim event documents.	the Claimant
	NAV shall be provided as on the Date of Valid Claim intimation if submitted up to 3 pm or the next working day of the valid claim intimation date.	(Please affix signature across
	Every field should be properly, correctly and completely filled up.	the photograph)
	This form is to be filled for ALL DEATH Claims – Death of the Life Insured	
	or Death of the Policyholder, where Waiver of Premiums rider has been opted for.	
	 This form needs to be filled up by the Policyholder, if different from the Life Insured or the Assignee if the policy is assigned or the Nominee registered with KLI as the case may be. In case, the Policyholder / Assignee / Registered Nominee have died at the time of this intimation, then this form needs to be filled up by the respective legal heirs. Please submit this form along with the requirements mentioned below at your nearest branch or Claims Department, 7th Floor, Zone -2 Kotak Infiniti, Building no. 21, Infinity Park, Off Western Express Highway, General A K Vaidya Marg, Malad (E), Mumbai – 400 097. 	
	 The Company reserves the right to call for any information / additional document(s) / Requirement(s) as it may deem necessary. 	
1. Policy Details (K	(indly provide all policy numbers incase if Insured Person had multip	le policies)

Documents to be submitted	Natural	Death	Unnatui	ral Death		
Mandatory Documents	Req	Y/N	Req	Y/N		
Duly filled Death Claim Intimation Form	√		√			
Original Policy Documents	√		√			
Original Death Certificate issued by municipality or equivalent authority	√		√			
Claimant's Photograph, Current Address Proof and Photo ID Proof	√		√			
Copy of bank passbook/statement of the claimant bearing IFSC Code	√		√			
Supporting Documents						
Medical certificate stating cause of death	√		×			
Medical Records (Consultation notes, treatment records, admission notes, hospital indoor papers, discharge / death summary, investigation reports etc)	√		<			
Medical Questionnaire / Physician Statement	√		×			
Copy of duly certified First Information Report /Inquest / Panchnama (translation mandatory in case vernacular language)	×		√			
Copy of duly certified Post Mortem Report / Chemical Analysis Report (Viscera)	×		/			
Copy of Driving License if the Insured Person was driving the vehicle at the time of accident.	×		/			
Settlement Option Form as applicable (refer point # 3)	√		/			
Any other Document (Please specify)						
2. Details of Claimant: (Current Address Should Match with the Address Proof Provided	d)					
Name (Full Name)						
Maiden Name (Full Name)						
Date of Birth D D M M Y Y Capacity in which claim is made Proposer Appointee Assignee Legal Heir						
COMMUNICATION ADDRESS OF THE Kindly tick the address proof submitted						

 $This is just an intimation of Claim to the Company. \ This intimation is not admittance of the Claim by the Company. \\$

DEATH CLAIM INTIMATION A DOINT VENTURE WITH & DOLD MUTUAL	ON FORM INDIVIDUAL POLICY CLAIMS						
Passport Vote	er Identity Card Driving License Electricity Bill						
Ration card	Bank Statement /Passbook updated till the previous month						
	·						
Aadhar Card \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	/alid Lease Agreement with rent receipt of recent 3 months						
State: Pin code: Telephone Bill	Any other (Kindly Specify)						
Telephone S T D L A N D L I N E	Mobile No						
Relationship with Insured Person	EMAIL ID						
Bank A/c Details Bank Name Branch I	Name & Address						
A/C No.	IFSC Code						
I HEREBY GIVE MY CONSENT TO DIRECT CREDIT / NEFT / RTGS CLAIM AMOUNT IN MY ACCOUNT: YES NO							
3. Payment Option Details:							
Kotak Smart Advantage Plan (107L043V01) / Kotak Head start Future Protect (107L037V01/ 107L038V01) / Kotak Long Life Secured Plus (107L044V01) (Please tick as applicable)**							
Lump Sum	Installment						
For Kotak Premier Endowment Plan 107N079V01, kindly fill	up the separate settlement option form specific to the plan.						
*Kotak Retirement Income Plan(All variants except KRIP with 107L033V01 / 107L032V01 / 107L024V01 / 107L026V01 / 107L02 *Kotak Guaranteed Pension Builder (107L057V01) / *Kotak Sa applicable)	Cover) (107N013V01 / 107N014V01 / 107L031V01 / 25V01) / *Kotak Secure Retirement Plan (107L049V01) /						
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Designation

Last Working

Day

Address (With landmark)

Nature Of Work



11. Authorization & Declaration

DEATH CLAIM INTIMATION FORM INDIVIDUAL POLICY CLAIMS

EMAIL ID			Contact No Mobile)	(Land	ine /								
6. Details of Death of Insured Person:													
Date of Death	DATE:				TIME								
Place of Death (Hospital, Hon	ne Any other	nlace)	DAIL.				1111411	TIME:					
Type of Death (PLEASE TICK	NATURAL	ACCI	DENTAL	SUIC	IDE	ML	IRDER	R	OTHE	RS			
Cause of Death and Event Lea													
Doctor / Hospital Contacted at													
How Long was the Insured Pe these symptoms	rson suffering	from											
Details of Doctor / Hospital Co	ntacted first												
7. To be Filled in case of U		th (Kindly	elaborate t	he spe	cific un	natural o	claim e	vent	e.g. a	accid	ents,	burns	etc):
Details of Unnatural Death				-					_				
Details of the Doctor / Hospita	contacted												
8. Details of Past History of	f Health / Hab	its of Ins	ured Persoi	า									
Nature of medical condition / habit (Please tick the relevant				evant box) Duration / First Date Diagnosis				If yes, give details (Kindly attach all medical documents)					
Hypertension Diabetes													
☐ Heart Disease ☐ Liver Dis	Cancer												
Respiratory Disease													
Any other ailments / disorder/surgery /hospitalisation													
Alcohol Smoking Tobacco Narcotics in any form													
9. Details of Family Physician: Name of Clinic / Hospital:													
Address:													
Telephone S T D	L A	N D	L I N	Mobil	e No.								
EMAIL ID													
10. Particulars of Other Life Insurance Policies [PLEASE MENTION DETAILS OF EVERY POLICY HERE]													
			mencement D	ate	Sum As	ssured		of Cla / Reject		Pendi	ng)		
	1												

This is just an intimation of Claim to the Company. This intimation is not admittance of the Claim by the Company. \rightarrow Intimation



DEATH CLAIM INTIMATION FORM INDIVIDUAL POLICY CLAIMS

Notwithstanding the provisions of any law, usage, custom or convention for the time being in force prohibiting any physician or Hospital or any other authority from divulging any knowledge or information acquired by him / her / them in attending upon or examining a person on the ground of secrecy, I hereby authorize any physician and any Hospital who has attended upon or examined or treated the aforesaid deceased life assured for any ailment or illness or any other authority to divulge any knowledge or information regarding the deceased's state of health which he / she / they may have acquired whether before or after the policy was issued by Kotak Mahindra Old Mutual Life Insurance Limited., to any of the authorized representatives of Kotak Mahindra Old Mutual Life Insurance Limited or at any of its offices or in any court of law. I,							
Signed at: Claimant	_ Date:	J		Signature / Th	umb Impression of the		
Witness Details:							
Name of Witness:				Conta	ct No. :		
Address:				Relatio	nship with claimant:		
Signed at: 12. 12.Authorization to C	Date:	<i>_</i>			Signature of Witness:		
12. 12. Authorization to C	ompany Re	presen	tatives to C	Contact the Cla	imant & Family		
to make calls / SMS's / em claim.	(les) of Kotak nails or perso	k Life in: onal visit	surance (Co s for docum	entation / requi	(Mobile number) (email id) have applied for a claim under the y authorize the Company and any of its representatives rement or any other enquiry in relation to the aforesaid		
					said claim, made by the Company and its		
representative, I shall not lodge a complaint for violation of TRAI guidelines on unsolicited phone calls and SMS's. Signed at: Date: / Signature / Thumb Impression of the Claimant							
Witness Details:							
Name of Witness:					Contact No. :		
Address:					Relationship with Claimant :		
Signed at:	Date:				Signature of Witness:		
Full Name of the Scribe : Contact No. : Complete Address :	Ç		acular langute of Birth:	uage or has affi	Relationship with Claimant :		
Signed at:	Data:	1	1		Signature of the Scribe:		