

6. Details of Death of Insured Person:

Date of Death

D	D	M	M	Y	Y	Y	Y
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 Time of Death _____ Place of Death (Hospital, Home, Any other place) _____

Type of Death (please tick) Natural Accidental Suicide Murder Others

Cause of Death and Event Leading to Death _____

Doctor / Hospital Contacted at the time of Death _____

How Long was the Insured Person suffering from these symptoms _____

Details of Doctor / Hospital Contacted first _____

7. To be Filled in case of Unnatural Death (Kindly elaborate the specific unnatural claim event e.g. accidents, burns etc):

Details of Unnatural Death _____

Details of the Doctor / Hospital contacted _____

8. Details of Past History of Health / Habits of Insured Person

Nature of medical condition/ habit (Please tick the relevant box)	Duration / First Date of Diagnosis	If yes, give details (Kindly attach all medical documents)
<input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Liver Disease		
<input type="checkbox"/> Kidney Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Respiratory Disease		
Any other ailments / disorder / surgery / hospitalisation		
<input type="checkbox"/> Alcohol <input type="checkbox"/> Smoking <input type="checkbox"/> Tobacco <input type="checkbox"/> 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	E
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 Mobile No

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Email ID: _____

10. Particulars of Other Life Insurance Policies (Please mention details of every policy here)

Name of the Company	Policy No	Risk Commencement Date	Sum Assured	Status of Claim (Paid / Rejected / Pending)

11. Authorisation

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 authorise 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 Life Insurance Company Limited., to any of the authorized representatives of Kotak Mahindra Life Insurance Company Limited or at any of its offices or in any court of law.

Date: ____/____/____ Place _____ Signature / Thumb Impression of the Claimant _____

12. Declaration

I, _____ do hereby; declare that the statements made herein above are true and complete in each and every respect. I understand that any incorrect or incomplete or misleading information in this form shall affect the claim settlement process and the decision of the Company. I agree to assist the Company in Claims Investigation. I also understand that in furnishing claim forms, Kotak Mahindra Life Insurance has not admitted liability or waived any of its rights.

*** Note: "The company cautions against payment of any charges/monies as against claim processing fees to any authorized/unauthorized agency/person claiming the same. Company does not charge any fees for claims process and instructs any such action to be brought to its notice."

Date: ____/____/____ Place _____ Signature / Thumb Impression of the Claimant _____

Witness Details:

Name of Witness: _____ Contact No. : _____

Address: _____

Relationship with claimant: _____

Date: ____/____/____ Place _____ Signature / of the Witness _____

13. Authorisation to Company Representatives to Contact the Claimant & Family

I./Mr./Mrs./Ms , _____ having _____ (Mobile number) _____ (Landline) _____ (email id) _____ have applied for a claim under the aforesaid insurance policy(ies) of Kotak Mahindra Life Insurance (Company), hereby authorize the Company and any of its representatives to make calls / SMS's/emails or personal visits for documentation / requirement or any other enquiry in relation to the aforesaid claim.

I also undertake that for such enquiry calls / SMS's in relation to the aforesaid 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.

Date: ____/____/____ Place _____ Signature / Thumb Impression of the Claimant _____

Witness Details:

Name of Witness: _____ Contact No. : _____

Address: _____

Relationship with Claimant: _____

Date: ____/____/____ Place _____ Signature / of the witness _____

Scribe Details: (Please fill, if the claimant has signed in a vernacular language or has affixed his / her thumb impression)

Full Name of the Scribe : _____

Contact No. : _____ Date of Birth

D	D	M	M	Y	Y	Y	Y
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 Relationship with claimant: _____

Complete Address : _____

Date: ____/____/____ Place _____ Signature of Scribe _____

Kotak Mahindra Life Insurance Company Ltd

Registered Office: 8th Floor, Plot # C- 12, G- Block, BKC, Bandra (E), Mumbai - 400 051 . Maharashtra, India.

Office: 9th floor, Intellion Square TRIL IT 4, Off Western Express Highway, General A K Vaidya Marg, Malad (E), Mumbai - 400 097

Toll free No: 1800 209 8800, Timings : 08:00 AM to 10:00 PM (Monday to Saturday) (excluding public holidays) Email id: kli.claimsmitra@kotak.com, Website: www.kotaklife.com.

CIN:U66030MH2000PLC128503. IRDAI Reg. No. 107.