RIDER / ILL HEALTH CLAIM INTIMATION FORM
INDIVIDUAL POLICIES

kotak Life Insurance
A JOINT VENTURE WITH OMD MUTUAL

AFFIX BRANCH SEAL

Instruction for filling up the form

- This form is to be filled for ALL Rider Claims / IIL Health Claims.
- This Form needs to be filled in by the Life Insured, as the case may be.
- Please submit this form along with the requirements mentioned below at the 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.
- **Every field should be properly and correctly filled up. Please ensure complete details are given**

Photograph of the Life Insured

(Please affix signature across the photograph)

Documents to be submitted	**CIB**		**PDB**		**ILL Health**	
Mandatory Documents	**Req**	**Y/N**	**Req**	**Y/N**	**Req**	**Y/N**
Duly filled Rider Claim Intimation Form	✓		✓		✓	
Original Policy Documents	✓		✓		✓	
Life Insured's Photo, Current Address Proof & Photo ID Proof	✓		✓		✓	
Supporting Documents						
Life Insured's copy of Bank Passbook/Statement with account details	✓		✓		✓	
Medical Records (Consultation notes, treatment records, admission notes, hospital indoor case papers, discharge / death summary, investigation reports etc)	✓		✓		✓	
Critical Illness Questionnaire / Medical Questionnaire / Physician Statement	✓		✓		✓	
Copy of duly certified First Information Report / Inquest /Panchnama (translation mandatory in case vernacular language)	×		✓		✓	
Copy of Driving License if the Life Insured was driving the vehicle at the time of accident.	×		✓		✓	
Disability Certificate from Government Authority	×		✓		✓	
Settlement Option Form as applicable (refer point # 4)	×		×		✓	
Any other Document (Please specify)_____						

1. Policy Details (Kindly provide all policy numbers incase if Insured Person had multiple policies)

2. Details of Life Insured: (Current Address Should Match with the Address Proof Provided)

Name (Full Name)			
Maiden Name (Full Name)			
Address:	**PERMANENT RESIDENTIAL ADDRESS:**	**CURRENT RESIDENTIAL ADDRESS:**	
STATE		**Pin Code**	
STATE		**Pin Code**	
Telephone	S T D L A N D L I N E	**Mobile No.**	
Relationship with Insured Person		**EMAIL ID**	

I HERE BY GIVE MY CONSENT TO DIRECT CREDIT / NEFT / RTGS CLAIM AMOUNT IN MY ACCOUNT: YES ☐ NO ☐

Bank A/c Details	**Bank Name** **Branch Name & Address**		
A/C No.		**IFSC Code**	

3. Employment Details of Insured Person :

Last Business / Employer Name			
Address (Along with Landmark)			
Nature Of Work		**Designation**	
Last Working Day		**Email Id**	
Telephone	S T D L A N D L I N E	**Mobile No**	

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4. Payment Option Details (Applicable only in IIL health Claims & in Plans as stated)

***Kotak Retirement Income Plan (All variants except KRIP with cover**)** (107N013V01 / 107N014V01 / 107L031V01 / 107L033V01 / 107L032V01 / 107L024V01 / 107L026V01 / 107L025V01) **/ *Kotak Secure Retirement Plan** (107L049V01) **/ *Kotak Guaranteed Pension Builder Plan** (107L057V01)

(**Please tick as applicable**)

☐ Entire Amount as Lump Sum	☐ Entire Amount as Annuity	☐ Part as Annuity - Part as Lump Sum

Kotak Capital Multiplier Plan*** (107N011V01)

☐ Entire Amount as Lump Sum	☐ Part as Lump Sum - Part as Instalment

***** I further declare that I will bear any tax liability accuring to me on account of taking the full refund of the amount instead of purchasing an annuity.

** KRIP with Cover UL (K04B) – maximum 1/3rd amount will be paid as lump sum & remaining will be paid as annuity.

*** Kotak Capital Multiplier Plan – Between 0 % and 50 % will be paid as lump sum & remaining will be paid as installments.

5. Past History of Health / Habits of Life Insured

Nature of medical condition / habit	Please write "Yes" / "No"	Duration / First Date of Diagnosis	If yes, treatment details (Kindly attach all medical documents)
Hypertension			
Diabetes Mellitus			
Coronary Artery Disease / Heart Disease			
Respiratory Disease			
Liver Disease			
Kidney Disease			
Cancer			
Any other Disease (not mentioned above)			
Alcohol in any form			
Smoking / Tobacco / Narcotics in any form			

6. Critical IILness Rider Claim ☐ IIL Health Claim ☐

6 (a) Critical IILness Claim Event (Please tick on the illness claimed, as is applicable as per the policy terms and conditions)

☐ **Heart Attack (Myocardial Infarction)**	☐ **Stroke**	☐ **Aorta surgery**	☐ **Major burns**
☐ **Major organ transplant**	☐ **Kidney Failure**	☐ **Loss of Limbs**	☐ **Blindness**
☐ **Coronary artery by-pass graft surgery (CABG)**	☐ **Cancer**	☐ **Heart valve surgery**	☐ **Paralysis**

6 (b) IIL Health Claim

Cause of Claim Event	

6 (a / b) Details of Claim Event

Date of Diagnosis	
Presenting Signs / Symptoms	
Duration of these symptoms	
Doctor / Hospital Contacted first time	
Details of the investigation carried out by the doctor	
Details of treatment	

7. Details of Permanent Disability Rider Claim

Date of Accident	D	D	M	M	Y	Y	Details of Accident	
Details of the doctor / Hospital contacted after the accident								

Describe the disability suffered	☐ **Unable to use both hands over the wrist**	☐ **Unable to use one hand at or above the wrist and one foot at or above the ankle**
	☐ **Unable to use both legs at or above the ankle**	☐ **Blind in both eyes**
	☐ **Unable to earn an income from the date of the accident onwards from ANY work, occupation or profession [commensurate with his educational qualifications, training and experience]**	

8. Particulars of Other Life Insurance Policies [PLEASE MENTION DETAILS OF EVERY POLICY HERE]

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

9. Authorisation & Declaration

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 Old Mutual Life Insurance Limited., to any of the authorised representatives of Kotak Mahindra Old Mutual Life Insurance Limited or at any of its offices or in any court of law.

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 Life Insurance has not admitted liability or waived any of its rights.

Signed at: _____ Date: ____/____/ 20____ Signature / Thumb Impression of the Claimant: _____

Witness Details:

Name of Witness: Contact No:

Address:

Signed at: _____ Date: ____/____/ 20____ Signature of the Witness:_____

10. 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 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.

Signed at: _____ Date: ____/____/ 20____ Signature / Thumb Impression of the Claimant: _____

Witness Details:

Name of Witness: Contact No:

Address:

Signed at: _____ Date: ____/____/ 20____ Signature of the Witness:_____

[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: Relationship with Claimant:

Complete Address :

Signed at: _____ Date: ____/____/ 20____ Signature / Thumb Impression of the Scribe: _____

kotak Life Insurance A JOINT VENTURE WITH OLD MUTUAL plc	RIDER / ILL HEALTH CLAIM DISCHARGE FORM INDIVIDUAL POLICIES

CLAIM DISCHARGE FORM

Instructions for filling up the form:

1. Please fill this form in BLOCK LETTERS using black or blue ink.
2. This form must be filled by the **CLAIMANT** only.
3. This form must be sent to "Claims Department", Kotak Mahindra Old Mutual Life Insurance Ltd. Kotak Infiniti, 7th Floor, Zone 2, Building no. 21, Infinity Park, Off Western Express Highway, General A K Vaidya Marg, Malad (E), Mumbai – 400 097.

I Mr. / Ms. _____residing at _____

_____(Complete Current Residential Address)

hereby declare and confirm that I am Life Insured Mr. / Ms. _____

I hereby acknowledge receipt from Kotak Mahindra Old Mutual Life Insurance Ltd. sum of ₹. _____

Rupees (in words) _____vide cheque no. _____ dated _____drawn on _____Bank _____ Branch towards full and final settlement of Claim under Policies mentioned below.

Policy No.								Amount (₹.)	Description (Basic Sum Assured / Rider Sum Assured)

I hereby discharge Kotak Mahindra Old Mutual Life Insurance from it's liability under the said policy (s).

Revenue Stamp

Signature of Claimant

Signed at _____ on _____this day of _____20_____

(Place) (Date) (Month) (Year)

Signature of Witness:

Name of Witness:

Address of Witness:

This should be treated as full and final settlement of the claim subject to realization of the cheque.

Claim Discharge Form: This is Full & Final Discharge of the Claim by the Company in respect of the claim/s mentioned above →Acknowledgment