

DEATH CLAIM FORM - GROUP PARTICIPANT

Form Completion Instruction:

- 1) This form may be completed by those having a claim benefits as a person nominated by the Participant, Guardian, Assignee, Trustee or a successor
- 2) Please fill the form with single pen without omissions / deletions
- 3) Please complete the form with legible handwriting, incomplete form may cause delay in processing of claim benefits
- 4) This form should be duly attested by notary public, Nazim of a union council or above, executive of TPL Life Insurance Ltd. - Window Takaful Operations or class 1 officer of the federal/provincial government.

CHECKLIST OF DOCUMENTS REQUIRED:

1. Claimant Statement ☐
2. Physician Statement ☐
3. CNIC - Deceased ☐
4. Death Certificate - Hospital ☐
5. Death Certificate - NADRA ☐
6. Treatment Records ☐
7. CNIC Cancellation Certificate – NADRA ☐

Additional Requirements for Group Life:

1. Salary Record ☐
2. Attendance Record ☐

Additional Requirements for Individual Life:

1. Assignment Letter ☐
2. Original Policy Documents ☐
3. Copy of Passport - Deceased & Claimant (if living abroad) ☐
4. CNIC - Nominee ☐

Additional Requirement, if Accidental Death:

1. Copy of Autopsy ☐
2. Copy of FIR ☐
3. Newspaper article covering the accident ☐
4. Medico Legal Report, if any ☐

***In order to validate the claim, TPL Life Insurance Limited - Window Takaful Operations reserve the right to ask for further requirements, if deemed necessary.**

CLAIM FORM A: INFORMATION ABOUT CLAIMANT / POLICY HOLDER

(To be completed by the claimant)

Name of Company / Claimant: _____
Takaful Policy Number: _____ Policy Period: _____

CLAIM PAYMENT INFORMATION:

Payment Through : _____ Cheque / IBFT
Name: _____ Account No.: _____
Bank Name: _____ Branch Name: _____
If it is through cheque: _____
Title of Cheque _____
Amount of Claim: _____

TPL LIFE INSURANCE LTD.

Window Takatul Operations

19-B, Lane 3, SMCHS,

In the lane of Roomi Masjid

Shahrah-e-Faisal, Karachi, Pakistan.

PARTICIPANT'S INFORMATION

(To be completed by the claimant)

PERSONAL DETAIL

Deceased Name : _____
Employee ID : _____
Father's / Husband's Name : _____
Gender: _____
Marital Status: _____
CNIC : _____
Date of Birth of Deceased : _____
Correspondence Address: _____

OCCUPATIONAL DETAIL

Occupation: _____
Designation: _____
Nature of Work : _____
Date of Joining : _____
Annual Salary (PKR): _____
Employer Contact No. : _____

Deceased covered with some other Insurance / Takaful Company? (If Yes, provide detail)

Sr. No.	Name of Company	Policy No.	Issuance Date	Address and Contact No.
1				
2				
3				

EVENT DETAILS

Type of Death: _____ Natural / Accidental _____ Date of Death: _____
Time of Death: (_____ : _____) AM/PM _____ Place of Death: _____
Duration of Illness: _____ / _____ / _____ TO _____ / _____ / _____

Illness complaint:

Date of Complaint	Details about complaint

Treatment details taken prior to death:

Sr. No.	Name of Hospital / Doctor Treated	Complaint About	Treatment Duration	Contact No.	Correspondence Address
1					
2					
3					

DECLARATION: I/We, as a claimant, hereby declare that the information provided in the form are true and complete to the best of my/our knowledge, belief, and record. I also hereby authorize TPL Life Insurance Ltd. - Window Takaful Operations in order to seek information from any doctor, hospital, laboratory, any other organization or person that has any record information or acknowledge of health/treatment and from any other Insurance / Takaful company to which a proposal has any time been made, and the giving of such information.

Claimant Signature

Date of Statement

Name:

Designation & Place of Signature

Stamp

* This statement must be countersigned by any of the following: notary public, Nazim of a union council or above, executive of TPL Life Insurance Ltd. - Window Takaful Operations or class 1 officer of the federal/provincial government.

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CLAIM FORM B: PHYSICIAN'S STATEMENT

(To be completed by the Physician)

DECEASED INFORMATION:

Deceased Name: _____
 Father's Name/ Husband's Name: _____
 CNIC #: _____ DOB: _____ Age: _____
 Address of Deceased: _____

EVENT INFORMATION:

Date of Death: _____ Time of Death: (_____ : _____) AM / PM
 Place of Death : _____ Type of Death : Natural / Accidental
 Name of Hospital (If died in hospital): _____
 Interval between onset and death: From _____ To _____ No of Days _____
 Cause of Death: _____

Primary Cause:

Secondary Cause:

Any other disease / illness deceased is suffering from but not leads to death? :

PAST MEDICAL HISTORY:

First Complaint about current illness: _____ / _____ / _____
 Last Complaint about current illness: _____ / _____ / _____
 Prior to current illness, is the deceased in a regular consultation with you?

Yes / No

If yes, please provide details:

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Yes / No

Sr. No.	Name of Physician	Complaint About	Treatment Duration	Contact No.	Correspondence Address
1					
2					
3					

Date of Accident: _____ Time of Accident: (_____ : _____) AM/PM

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Investigation held?	Yes / No	(If yes, please attach findings)
Autopsy Performed?	Yes / No	(If yes, please attach report)

I _____ medical attendant of the life insured _____ do hereby declare that to the best of my knowledge and belief the information given herein are true and complete.

Signature

Date of Statement

Name:

Contact Number

Stamp

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Complaints in respect of insurance policy

"If you have any complaint or grievance against the insurance company, broker, agent, surveyor or bank representative in respect of your insurance policy, you may file your complaint with the following offices:

(1) **FEDERAL INSURANCE OMBUDSMAN**

2nd Floor, Pakistan Red Crescent Society
Annexe Building, Plot # 197/5
Dr. Doud Pota Road
Karachi.
Phone: 021-99207761-62
Website: www.fio.gov.pk/

(2) **Official Coordinator, Small Disputes Resolution Committee(Islamabad)**

The Management Executive, Insurance Division, 3rd Floor, NIC Building, 63-Jinnah Avenue, Blue Area, Islamabad.
Phone: 051-9207091-4 ext. 439
Email: complaints@secp.gov.pk

(3) **Official Coordinator, Small Disputes Resolution Committee (Karachi)**

The Deputy Director, Specialized Companies Division, 5th Floor, State Life Building No.2, Wallace Road Off. I.I. Chundrigar Road, Karachi.
Phone: 021-32414204
Email: complaints@secp.gov.pk

(4) **Official Coordinator, Small Disputes Resolution Committee(Lahore)**

The Deputy Registrar of Companies, Company Registration Office-Lahore, Associate House, 3rd & 4th Floor, 7-Egerton Road, Lahore.
Phone: 042-99204962-66 ext. 28
Email: complaints@secp.gov.pk

بیمہ پالیسی کے متعلق شکایات

اگر آپ کو اپنی بیمہ پالیسی کے متعلق انشورنس کمپنی، بروکر، ایجنٹ، سرویئر یا بینک نمائندے کے خلاف کوئی شکایت ہو تو آپ درج ذیل دفاتر میں رابطہ کر سکتے ہیں:-

وفاقی انشورنس منتخب۔

سیکنڈ فلور، پاکستان ریڈ کریسنٹ سوسائٹی، انیکسی بلڈنگ،
پلاٹ نمبر 197/5، ڈاکٹر داؤد پوتا روڈ، کراچی

فون: 021-99207761-62
www.flo.gov.pk

دفتری رابطہ کار (لاہور)

اسمال ڈسپوٹس ریزولوشن کمپنی

سیکورٹیز اینڈ ایکسچینج کمیشن آف پاکستان

ایسوسی ایٹ ہاؤس، 3rd فلور، 07- ایجرٹن روڈ، لاہور۔

فون نمبر: 042-99204962-66 (Ext 28)
ای میل: complaints@secp.gov.pk

دفتری رابطہ کار (اسلام آباد)

اسمال ڈسپوٹس ریزولوشن کمپنی

سیکورٹیز اینڈ ایکسچینج کمیشن آف پاکستان

تھرڈ فلور، این آئی سی ایل بلڈنگ، اسلام آباد

فون: 051-9207091-4 ایکسٹنشن 439
ای میل: complaints@secp.gov.pk

دفتری رابطہ کار (کراچی)

اسمال ڈسپوٹس ریزولوشن کمپنی

سیکورٹیز اینڈ ایکسچینج کمیشن آف پاکستان

5th فلور، اسٹیٹ لائف بلڈنگ 02، ولاس روڈ،

آف آئی آئی چندریگرہ، کراچی۔

فون: 021-32414204