DEATH CLAIM FORM - GROUP LIFE & INDIVIDUAL LIFE

CLAIM FORM : ☐ **GROUP LIFE** ☐ **INDIVIDUAL LIFE**

Form Completion Instruction:

1) This form may be completed by those having a claim benefits as a person nominated by the Policy Holder, 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. 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 ☐

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 reserve the right to ask for further requirements, if deemed necessary.**

CLAIM FORM A: INFORMATION ABOUT CLAMAINT / POLICY HOLDER

(To be completed by the clamaint)

Name of Company / Claimant: _____

If claiming for individual life, please provide below information:

Father's / Husband's Name : _____

Relationship with Deceased : _____ D.O.B : _____

Gender : _____ Contact No. : _____

CNIC : _____ Email ID : _____

Claiming as: ☐ Nominee ☐ Beneficiary

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: _____

INFORMATION ABOUT DECEASED

(To be completed by the clamaint)

PERSONAL DETAIL		OCCUPATIONAL DETAIL	
Name :		Employee ID :	
Father / Husband's Name :		Occupation:	
Gender:		Designation:	
Marital Status:		Nature of Work :	
CNIC :		Date of Joining :	
D.O.B :		Annual Salary (PKR):	
Correspondence Address:		Employer Contact No. :	

Deceased covered with some other insurance 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: DD / MM / YYYY TO DD / MM / YYYY

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 Limited 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
(For Group Life, need duly stamped)

Date of Statement

Countersigned By:

Designation & Place of Signature

Date of Statement

*** 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. or class 1 officer of the federal/provincial government.**

CLAIM FORM B: PHYSICIAN STATEMENT

(To be completed by the Physician)

DECEASED INFORMATION:

Deceased Name: _____

Father/ Husband's Name: _____

CNIC #: _____ DOB: _____

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: ( ) 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: DD / MM / YYYY

Last Complaint about current illness: DD / MM / YYYY

Prior to current illness, is the deceased in a regular consulation with you?	Yes / No

If yes, please provide details:

Have you referred the deceased any other physician or hospital for any treatment? Yes / No

If yes, please provide following details:

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

IF ACCIDENTAL DEATH / SUICIDE:

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

Describe event in detail:

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

DECLARATION:

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 & Duly Stamp with date:

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