

3S CLAIMANT'S STATEMENT FORM (DEATH CLAIMS)

The Claimant's statement form must be filled by the claimant / beneficiary under the policy or by the legally entitled person

1. POLICY DETAILS: (Mandatory)

8 digit policy number(s):
 (Please mention all policy numbers with ICICI Prudential Life Insurance Co. Ltd.)

2. CLAIMANT DETAILS (Current residential address should match with address proof provided):

Name: Relationship with life assured:
 Date of birth: DD/MM/YYYY Address:
 Pincode: Telephone with STD code:
 Mobile number: Alternate Mobile number:
 Convenient time to call: Email ID:
 Pan number:

3. DETAILS OF DECEASED LIFE ASSURED: (Mandatory)

Name: Fathers Name:
 Date of birth: DD/MM/YYYY Date of death: DD/MM/YYYY
 Place of death: Hospital / Clinic Residence Office Others Please specify:
 Age at death:

CAUSE OF DEATH / NATURE OF ILLNESS / HABIT (Please tick ✓/*)	Date of diagnosis of illness
<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"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Tobacco <input type="checkbox"/> Drugs	
<input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Others	
Any hospitalisation / Illness in last 5 yrs. <input type="checkbox"/> Yes <input type="checkbox"/> No Details	

Name & Telephone number of the Doctor who declared death:
 Name & Address of Police Station where FIR was lodged (if any):

4. TREATMENT / DIAGNOSIS OF ILLNESS: (Mandatory)

Nature of the illness:
 Date of diagnosis: DD/MM/YYYY Date of admission: DD/MM/YYYY Date of discharge: DD/MM/YYYY
 Name of treating doctor / Hospital: Address:
 Telephone with STD code:

5. EMPLOYMENT DETAILS: (Mandatory)

Last employer's / Business name:
 Designation: Last working date:
 Address:
 Telephone with STD code:

6. PARTICULARS OF OTHER LIFE INSURANCE / MEDICLAIM POLICIES HELD BY THE LIFE ASSURED (Mandatory)

Name of the Company / TPA	Policy number	Sum assured

7. ARE YOU A POLITICALLY EXPOSED PERSON (CLAIMANT)? Yes No

Politically Exposed Persons (PEPs) are individuals who are or have been entrusted with prominent public functions in a foreign country, example, Heads of State or of Governments, senior politicians, senior government / judicial / military officials, senior executives of state owned corporations, important political party officials, etc., including their family members and close relatives.

8. LIST OF DOCUMENTS TO BE SUBMITTED:

Requirements submitted along with this form	Please tick
Original Policy Document	<input type="checkbox"/>
Copy of Death Certificate issued by Local Authority	<input type="checkbox"/>
Claimant's current address proof	<input type="checkbox"/>
Claimant's photo identity proof	<input type="checkbox"/>
Cancelled cheque / Copy of bank passbook*	<input type="checkbox"/>
Copy of Medico legal cause of Death Certificate	<input type="checkbox"/>
Medical Records (admission notes, discharge summary, indoor case papers, test reports etc.)	<input type="checkbox"/>
Prior medical records of Insured/Life Assured	<input type="checkbox"/>
Medical Attendant certificate/ Hospital certificate issued by doctor	<input type="checkbox"/>
Post Mortem Report and chemical viscera report (If applicable)	<input type="checkbox"/>
FIR/ Panchnama/ Inquest Report and final investigation report (If applicable)	<input type="checkbox"/>
Employer's Certificate of the Insured/Life Assured	<input type="checkbox"/>
Copy of Driving License (If applicable)	<input type="checkbox"/>

*As per the regulatory requirement, Insurers are required to pay all payouts due to policyholders / nominee / assignee by directly crediting the money into their bank account.

Note: The Company reserves the right to call for additional requirements, if needed

9. CLAIM BENEFIT PAYOUT OPTION (wherever applicable as per product terms and conditions)*

For (a),(b),(c)

*Benefit option selected at policy inception cannot be changed, only payout method can be changed at claims stage.

*Change in payout method at claims stage is not applicable if benefit option "Lump sum" is chosen at policy inception.

#Interest rate used for deriving present value of future payouts is 4% p.a.

For (d)

*option d will be applicable for product IPRU Lakshya only. Please refer policy document for details.

Disclaimer - If the instalment payment is less than the minimum instalment amount, the claim proceeds shall be paid in lump sum only

(a) Income Option	<input type="checkbox"/> As opted at policy inception	<input type="checkbox"/> Advance 1 st year's income as lump sum and remaining in monthly instalments	<input type="checkbox"/> Lump sum (Present value of future payouts) [#]
(b) Increasing Income Option	<input type="checkbox"/> As opted at policy inception	<input type="checkbox"/> Advance 1 st year's income as lump sum and remaining in monthly instalments	<input type="checkbox"/> Lump sum (Present value of future payouts) [#]
(c) Lump sum and Income Option	<input type="checkbox"/> As opted at policy inception	<input type="checkbox"/> Lump sum (Present value of future payouts) [#]	
(d) Option to take Death Benefit in installment			
Installment period	<input type="checkbox"/> 5 Years <input type="checkbox"/> 10 Years <input type="checkbox"/> 15 Years		
Mode of Installment payment	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Half yearly <input type="checkbox"/> Yearly		
Percentage of lump sum			

10. ELECTRONIC PAYOUT OPTION (Direct transfer of funds to your Bank Account) Please submit cancelled cheque / cheque copy along with this form

Name of account holder:

Mobile number: Bank name:

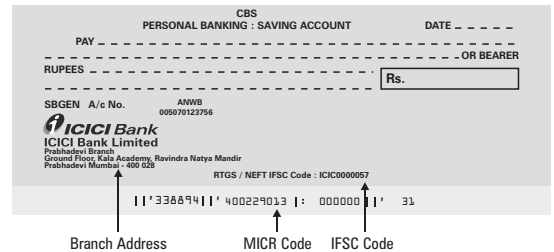
Branch name & address:

Bank account no.:

MICR code:

9 digit code as appearing on the Cheque copy issued by bank. Please attach a copy of cancelled Cheque for verifying MICR code.

IFSC code:



The payout mode selected in this form would be used by the Company to make all payout(s) to the claimant. Payouts would be in accordance and subject to the terms and conditions of the policy. Further the Company reserves the right to use any alternative payout option including demand draft/payable at par cheque inspite of opting for electronic payout method. Responsibility of providing IFSC code lies with the customer. Please note that IFSC code for RTGS & IFSC code for NEFT may be different. I will not hold ICICI Prudential Life Insurance Company Ltd. responsible in cases of non-credit to my bank account or if the transaction is delayed or not effected at all for reasons of incomplete / incorrect information.

x
Signature / Thumb impression of the claimant

Place: Date: DD/MM/YYYY

11. ICICI BANK Account details, if any, held in the name of Life Assured* (This information will be passed onto ICICI Bank for closure formalities):

ICICI Bank account number:

AUTHORIZATION / DECLARATION

Insurance Policy Number (s):

I, Mr. / Ms. / Mrs. (Name of the claimant) (relation) of Mr. / Ms. / Mrs. (Name of the Life Assured)

do hereby declare that the above statements are true in each & every respect. I hereby give my consent to ICICI Prudential Life Insurance Co. Ltd. and its representatives to obtain information / documents (including photocopies) from past and the present employer(s) / Business Associates / Medical Practitioners / Hospitals (Government / Private) / Birth and Death Registrar / Any life and non-life insurance company and Life Insurance Association's Medical Register. I hereby request hospital/ relevant authorities to release to ICICI Prudential Life Insurance Co. Ltd. and its representatives any details regarding state of health, habits and occupation of the life assured within his/ her knowledge before or after the policy was issued and ICICI Prudential Life Insurance Co. Ltd. to release to any Life and non-life insurance company / or Life Insurance Association's Medical Register, such details and provide the record of employment / business or other details as may be considered relevant.

In case where Sum Assured is zero / Investment plan / Paid-up policies, where the Policy document is not submitted to the Company and where the total payment is not more than ₹ 5 lakhs, I hereby agree to indemnify the Company against all liabilities that the Company may incur on account of any claim being made by any other person on the basis of possession of the Policy document or otherwise.

Please note: Claim benefits under Pension Products will be paid in lump-sum unless requested for periodic pension.

Yours faithfully,

Signature / Thumb impression of the claimant / Nominee	Name & signature of the witness
x Submit your identity & address proof	Relation with claimant
Mobile number	Mobile number
Place: Date: DD/MM/YYYY	Place: Date: DD/MM/YYYY

FOR OFFICE USE ONLY (BRANCH OPERATIONS):

Claim submitted time:

Before 3 pm

After 3 pm

Nominee name:

(Nominee name should match with name mentioned in policy certificate)

Nominee ID & address proof collected Y / N If N reason: _____

Policy status: _____

Claim submitted by Nominee Family member Advisor

Other (Please specify) _____

Name of the claims assessor contacted: _____ Phone no.: _____

SPAARC call ID: _____

Please scan the documents in Omni docs under Claim service documents

STAMP & TIME

*Please note the company is only facilitating the closure of the account and shall not be held responsible in case of any delay or failure on part of the bank to close the account. For any clarification in this regards, you are requested to directly coordinate with the bank.



ACKNOWLEDGMENT SLIP (DEATH CLAIMS)



Policy number(s) _____

Name of claimant's _____

Branch name & code _____

Date DD/MM/YYYY _____ Employee name & code _____

Documents submitted:	Please tick
Original Policy Document	<input type="checkbox"/>
Copy of Death Certificate issued by Local Authority	<input type="checkbox"/>
Claimant's current address proof	<input type="checkbox"/>
Claimant's photo identity proof	<input type="checkbox"/>
Cancelled cheque / Copy of bank passbook*	<input type="checkbox"/>
Copy of Medico legal cause of Death Certificate	<input type="checkbox"/>
Medical Records (admission notes, discharge summary, indoor case papers, test reports etc.)	<input type="checkbox"/>
Prior medical records of Insured/Life Assured	<input type="checkbox"/>
Medical Attendant certificate/ Hospital certificate issued by doctor	<input type="checkbox"/>
Post Mortem Report and chemical viscera report (If applicable)	<input type="checkbox"/>
FIR/ Panchnama/ Inquest Report and final investigation report (If applicable)	<input type="checkbox"/>
Employer's Certificate of the Insured/Life Assured	<input type="checkbox"/>
Copy of Driving License (If applicable)	<input type="checkbox"/>

*As per the regulatory requirement, Insurers are required to pay all payouts due to policyholders / nominee / assignee by directly crediting the money into their bank account.

Note: The Company reserves the right to call for additional requirements, if needed

- Where sum assured is zero (Pension Plans) fund value as on date of intimation is payable
- The acknowledgment slip should not be construed as acceptance of claim. The Company reserves the right to call for additional documents / requirements

STAMP & TIME

CLAIM CONTACT POINTS



24x7 ClaimCare Cell:

Customer Care No: 1860 266 7766
Call Center timings:
10.00 A.M. to 7.00 P.M. Monday to
Saturday (except national holidays)



Email us:

lifeline@iciciprulife.com



SMS Service:

ICLAIM<space>8 digit
policy no. to 56767

AUTHORIZATION

(To be signed by the claimant)

To,

Life Insurance Policy Number(s): _____

I, Mr./ Ms. _____ (name), _____ (relation) of
Mr./ Ms. _____ (name of the Life Assured) hereby give my consent to "ICICI Prudential Life
Insurance Company Ltd., and/ or its representative to obtain records (including photocopies)/ information pertaining to the
treatment/ occupation of the deceased.

- Employment records
- Medical records
- Govt. Hospital records
- Private hospital records
- Other records _____

(Please "tick" the boxes above)

Yours faithfully,

Claimant Signature

Witness Signature

Name of Claimant _____
(in block letters, family name first)

Name of the Witness _____
(in block letters, family name first)

Date: _____

Address of Witness: _____

Date: _____