

		D	EATH CLA	IN	\ FOR/	M (I	FORM-	- A)	
For Branch Office use only									
Date of claim receipt			Claim Submitted time		Before 3 pm		After 3 pm		
Name & Contact details	of GO person								
Claim Submitted by	Nominee		Family Member		Agent		Others		Branch Stamp
	eath Claim Ap	plicat	ion form is designed to	help	o you file you	r claim			esponsibility to offer you the best support ease return this form duly filled and signed
 IMPORTANT INFORMATION Claims under multiple policies may be registered by filling a single form & providing all applicable policy numbers. Claim is payable subject to the policy being inforce on the date of event and fulfillment of all terms and conditions of the policy. If there is more than one claimant, separate forms need to be filled for each of the claimant. This form needs to be witnessed by any of the following (1) Max Life Agent (2) Sales Manager / ADM/Office Head of Max Life (3) Block Development Officer (4) A bar manager of a nationalized bank with rubber stamp (5) An officer of Max Life company not below the rank of a manager (6) A Gazetted Officer (7) A Head Master / Principle of Govt. School (8) A Magistrate. Please read the declarations carefully and sign the claim form in the same manner as you would normally sign your cheques. Your signature would be used to verify the requests you give us in the future. 									
HOW TO COMPLETE YOU		d by th	e claimant in BLOCK lette	ers					
All fields in the claim form should be filled by the claimant in BLOCK letters. Section A - This section seeks information about the claimant: Please make sure that your current address and mobile number is mentioned, as we would do all the claims communication on this address and mobile number only, please provide your email-id in case you have one; Please mention your complete bank account details; and Please attach a NEFT Form attested by bank or a copy of cancelled cheque/bank account passbook to enable us to transfer the claim proceeds directly to your account subject to the claim being payable as per the terms and conditions of the policy.									
 Section B - This section seeks information about the Life Insured: Please mention the cause, date and time of death of the Life Insured; Please mention the names, addresses and telephone numbers of all doctors, hospitals or other medical sources who treated Life Insured during the last illness/accident and over the last three (3) years. If necessary, please attach additional sheets; and Please provide details of all life insurance policies of the Life Insured, with insurance companies other than Max Life Insurance. Section C-This section needs to be filled only if different death benefit options are provided under the plans as mentioned in the form. Section D-This section can be used, if you want to provide any additional information that is not covered in the claim form. 									
						(Plea	se tick appı	opriate	e boxes to indicate documents
that have been submitted) - [Marked with * are mandatory documents]									
1) *Original / Attested Copy of Death Certificate issued by local authorities									
2) *Original Policy Document(s)									
3) *Attested copy of you	r identity proo	f (any	one of the below-specif	ying y	1		f birth)		
PANCard					Voter ID Card				
Aadhaar Card				\vdash	Valid Driving				
	Valid Passport Others (please specify)								
4) *Bank details (any one of the below) Cancelled cheque with printed name and account details of Claimant									
Copy of bank passbook / bank statement									
NEFT form attested by bank									
Additional documents *FIR	Additional documents in case of Suicide / Accident - (FIR and Post Mortem Report is mandatory) *FIR Panchanama								
*Post Mortem F	Renort			\vdash	Paricilaliana News paper cu	ıttina (it	fany)		
Inquest report	•			\vdash	Final Police In				
questreport]	· cocigai			

Medical cause of death certificate

In case of Medical cause of death (Hospitalisation / Non-Hospitalisation) below documents are required

Attendant Physician Statement (FORM "C" to be filled by last attending doctor)



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DEATH CLAIM FORM (FORM- A)

Max Life Policy Number (s)				
Claim form is submitted through: Max Life Agent Max Life Office Bank Branch Others				
Declaration: I/We the claimant(s) do solemnly declare that the below answers and statements are true in all respects and further agree that the furnishing of this form, or any other form, or any other form supplemental thereto, to the company shall not constitute an admission by the company that there was any insurance in force on the life in question or a waiver of any rights or defense.				
Section A: Please tell us about yourself (claimant) - [Marked with * are mandatory fields]				
*Name:*Date of Birth: DDMMMYYYYY *Gender M F				
*Relationship with deceased life i	insured: Spouse Childi	ren Parents Others, Ple	ease Specify	
*Current Correspondence Addres	ss:			
	Sta	ite:	Pin Code:	
*Contact No.:	E	mail ID:		
PAN No.:	*E	Bank A/C No.:		
*Bank Branch Name & Address: _				
MICR Code:	*	FSC Code:		
Section B: Please tell us about the deceased Life Insured - [Marked with * are mandatory fields]				
*Name:			_*Age on Death: years	
*Last Occupation:Last Employer details (If applicable)				
*Date of death: $\begin{tabular}{ c c c c c c c c c c c c c c c c c c c$				
*Cause of Death: Medical Suicide Murder				
*Nature of illness/accident:*Date of diagnosis/accident: D D M M Y Y Y Y				
*Place of death: Hospital / Clinic Residence Office Others (please specify)				
*Please tell us details of the doctors who treated Life Insured during his/ her last illness/accident and/or during last 3 years:				
Name of Doctor / Hospital	Contact details	Date of first consultation	Treatment taken	
In case deceased life assured was insured with other life insurance companies, please provide details*:				

Name of Company	Policy Number	Policy Amount	Policy Issue Date	Claim Status



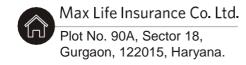
DEATH CLAIM FORM (FORM- A)

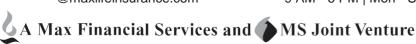
y of the claim.)	s under any of the following plans: (Selecting the
Lump sum benefit	Regular Monthly Income
Lump sum benefit	Regular Monthly Income
Immediate100%Payment	Immediate 50% payment & 50% as Monthly Income
n:	
New Annuity Plan	New Pension Plan
: Lump sum benefit	Regular Monthly Income
he claimant in vernacular and that he electronic transfer of money in my ab bank account with/without assigning a tion. Further, Max Life Insurance Co. Li if direct credit cannot be executed the claimant name particulars will not be	ession): Declaration from the Witness / Declarant to certify /she has affixed his/her signature /thumb impression hereto ove mentioned bank account. Max Life Insurance Co. Ltd. shall any reasons thereof or if the transaction is delayed or not effected to. reserves the right to use any alternative payout option. Credit will be effected based solely on the claimant account to e used thereof. / We agree to receive regular reminders/ alerts from Max Life
ormation including Aadhaar number, v	voluntarily, with Max Life and I hereby provide consent to Ma surer for the purpose of claims assessment/investigation wit
t Signature o	of Witness / Declarant
Name & ac	ddress:
Place:	
	Lump sum benefit Lump sum benefit Lump sum benefit Immediate 100% Payment Immediate 100% Payment Lump sum benefit Signature sum benefit Lump sum bene

- On assessment of documents submitted, Max Life reserves the right to call for additional documents.
- Any person who knowingly files a claim containing false or misleading information , or who conceals information with intent to defraud or mislead the Company or other person, may be guilty of felony or subject to other criminal and/or civil penalties as the case may be under the applicable $law(s). \ The \ company \ reserves \ the \ right \ to \ take \ appropriate \ action \ against \ the \ said \ person.$











DEATH CLAIM FORM (FORM- A)

Authorization (To be signed by the claimant)

In order to process your claim, additional documents may be required from different authorities. By signing this authorization, you give Max Life Insurance Co. Ltd. and/or its representatives the right to obtain the documents required on your behalf.

To,

Max Life Policy Number(s):					
I, Mr./ Ms	(name),(relation				
of Mr. /Ms	(name of the Life Insured) hereby give my consent to Max Life				
Insurance Co. Ltd., and/or its representative to obtain Original or photocopies of employment / medical / govt. / pvt. hospital records / other records / information necessary to process the claim					
Yours faithfully,					
Signature / Left thumb impression of Claimant	Signature of Witness / Declarant				
Name of Claimant:	Name & address:				
Place:					
Date: D D M M Y Y Y Y	Place:				
	Date: D D M M Y Y Y Y				