Max Life Insurance Company Ltd.
90 A, Sector-18, Udyog Vihar, Gurgaon-122015, Haryana
Phone Number- 0124-4219090, Extn-9517, Toll Free- 18002005577
Email- group.claims@maxlifeinsurance.com

Application form for Death Claim-Claimant's Statement – E&E

- This form is to be filled in by the Group Policyholder.
- The benefit is payable subject to policy being in force & member being active as on the date of insured event and also subject to fulfillment of all conditions/definitions as stated in the policy document.
- Submission of this form should not be construed as acceptance of claim.
- Submission of supporting documents with this form would enable the company to expedite the claim processing.
- **Fields marked as * are mandatory to be completed.**
- **Please fill up the form in Capital Letters.**

I. Claimant's Information (Group Policyholder)

1A) *Name of the Group Policy Holder:	1B) *Group Policy Number:
1C) *Capacity as a Claimant (Relationship):	1D) *Sum Assured:
1E)* Contact Details: E-mail ID -	1F)* Phone No. with STD Code -

Fields Below to be completed if the claim payment has to be made in favour of the beneficiary/nominee:

1G)*Name of the Beneficiary: *Relationship with member insured:	1H) *Bank A/c No. of the Beneficiary: *Bank Name:
1I)*Beneficiary's Contact No. :	1J): *Address of the Beneficiary:

II. Information of the deceased (Insured Member)

2A) *Full Name of the Deceased: *Gender: ☐ Male ☐ Female	2B) *Membership Number: Employment Number:
2C) *Date of Birth:	2D) *Date of Joining:
2E) *Please specify the date of coverage commencement of the deceased member: *Was the member actively at work on the date of coverage commencement? Yes_____No_____	
2F) *Last Date at work:	2G) *Date & Time of Death:
2H) *Immediate Cause of Death:	2I) Deceased's Job Profile/ Designation at the time of death:

Fields (3-6) below to be completed only if the cause of death is accident.

3) Date & Time of Accident:	4) Place of Accident:
5) Details of Accident (Type of Accident / Police Station & FIR No):	
6) Post-Mortem/Autopsy been done: Yes____ No ____ (If yes, please submit a copy)	

III. Declaration And Authorization

I/We, the above-named claimant(s), do solemnly declare that the foregoing answers and statements are true in all respects, and further agree that the furnishing of this 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 defence.

Notwithstanding, any law, custom or usage, prohibiting the furnishing of secret information obtained during the medical treatment / investigation of Life Insured, I/We hereby authorize any doctor or other person, or any hospital, sanatorium, medical professional, hospital or other medical care institution, insurance support organization, pharmacy, governmental agency, insurance company, employer, benefit plan administrator, accountant, or financial adviser or other institute to provide to MAX LIFE INSURANCE COMPANY LTD., any of its offices, or Court of Law, or any investigative agency or independent administrator acting on its behalf, information concerning employment, finances or insurance, advice, care or treatment provided to deceased, or any information that may be required concerning the health of the deceased (Life Insured) including information relating to mental illness, use of drugs, use of alcohol, HIV(AIDS Virus) and /or sexually transmitted diseases. A Photostat copy of this authorization duly attested by the gazetted officer/notary shall be considered as effective and valid as the original.

The Policy Holder shall hold all benefits received under this Policy UPON TRUST for the benefit of the person(s) to whom the benefits are payable and ensure payment to them in accordance with the applicable Rules and the Policy Holder shall have no beneficial interest in the same.

***Authorised Signatories of the Group Policy Holder**

Signature:

Name & Designation:
Company Seal
Place:

*** Witness- Mandatory**

Signature:

Name:
Address:

Dated this_____day of _____ month in the year _____

- **Note: - Please find enclosed the mandate form for Electronic Fund Transfer for all death claim amounts.**

Max Life Insurance Company Ltd.
90 A, Sector-18, Udyog Vihar, Gurgaon-122015, Haryana
Phone Number- 0124-4219090, Extn-9517, Toll Free- 18002005577
Email- group.claims@maxlifeinsurance.com

Electronic Funds Transfer- Mandate form

I _____ is a Nominee in Policy Number_____ in the Name of _____hereby request Max Life Insurance Co. Limited to make Claim payments, if payable, directly to my bank account as per detail given below.

Account Holder Name: _____

Type of Bank Account: _____

Bank Account Number: _____

Branch Address :_____

_____

MICR code :_____

IFSC code (Indian Financial Security code):_____

Declaration: I agree to save and hold Max Life Insurance Company Limited harmless and indemnified against any and/or all losses, claims, liabilities, legal proceedings (including attorney fees), expenses or damages suffered by or taken against Max Life Insurance Company Limited arising on account of any error or misrepresentation in the information furnished in this EFT mandate by me.

Nominees Signatures: _____

Date:

Bank Verification - Name of Bank:

I, undersigned/authorized person, on behalf of the above menntioned bank confirm that the bank account details of the individual as mentioned in this EFT mandate form are correct as per our records and are hereby verified.

Branch address, name & signature of Branch Manager
Bank verification stamp with Date:

Please attach a copy of cancelled cheque along with this form