Employer Employee Death Claim Form

(To be completed by the Group Policyholder (GPH) and Nominee for all Group Insurance Schemes)

Mandatory Documents to be submitted along with this form:

Mandatory Documents	Additional documents* to be submitted
1. Copy of valid death certificate issued by local authority 2. Photo identity proof of the nominee attested by GPH 3. Current address proof of the nominee attested by GPH 4. Cancelled cheque / Copy of bank passbook 5. PAN No./ Form 60 of the nominee 6. Legal heir/Succession certificate in case of absence of nominee 7. Authorization letter from the claimant incase the claim intimation is received through third party for claims received at the branch/GPH Note:- Please mask first 8 digits of Aadhaar number if Aadhaar Card is submitted as KYC proof with the request Above document are required for registration purpose, Company may ask additional documents for processing of the claims	**Natural death/ death due to illness** 1. Complete Medical records (Admission notes & Discharge / Death summary & Test / investigation reports etc.) for any treatment taken in past or at the time of death attested by GPH 2. Leave details for Group Term Life claims if active work clause is applicable (E&E case) **Accidental Death** 1. Copy of FIR, Panchnama, Inquest report, Postmortem report* 2. Obituary/ Newspaper cutting (if available)* 3. Viscera / Chemical analysis report (if applicable)* 4. Final police investigation report* *Attested by GPH

Part A:

1) Group Policy No.: _____ 2) Member ID: _____

3) Employee ID: _____ 4) Current Designation/Band/Grade of deceased Member: _____ (with date of effect) as required under applicable quote

5) Full Name & Address of Insured Member / Employee: _____

_____

6) Name of Group Policyholder: _____

7) Date of Birth of Insured: _____ 8) Date of Joining the Service: _____ 9) PAN No./ Form 60: _____

10) Date of Death: _____ 11) Place and Cause of Death: _____ 12) Cause of Death _____

13) Last Drawn Salary: (Mandatory for GTL/ FSL Scheme, please provide basic salary for FSL claim. Please mention the salary as required under applicable quote)	Monthly	Annual

14) Particulars of Leave availed by the Employee during last one year/ from the date of event. Please mention

From Date	To Date	No. of Days	Type of Leave	Reason

15) Sum Assured: _____

16) PF Account Number of Insured Member: _____ (Mandatory for EDLI Claim)

17) Please confirm employment status of the employee as on date of joining Permanent ☐ Contractual ☐

18) Please confirm whether employee was actively at work as on date of joining: Yes ☐ No ☐

19) Last working date: _____

Declaration and authorization by Group policy holder

I/We, the above named claimant/s, do solemnly declare that the foregoing statements are true and agree that furnishing this form, or any other form supplemental there to, by the Company, shall not constitute an admission by it that there was any insurance in force on the life in question or a waiver of any rights or defense. Notwithstanding, any law, custom or usage, prohibiting the furnishing of secret information obtained during the medical treatment/investigation of member.

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 advisor or other institute to provide to PNB MetLife India Insurance Company Ltd, any of it 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 Insured Member, or any information that may be required concerning the health of the Insured Member including information relating to mental illness, use of drugs, use of alcohol, HIV(AIDS) and/ or sexually transmitted diseases. A Photostat copy of this authorization shall be considered as effective and valid as the original.

I/We hereby further consent, and authorize, PNB MetLife to use and disclose any of the personal and sensitive information of mine/our collected or available with PNB MetLife (whether contained in this statement/application or obtained otherwise) which may include KYC documents to any individual/organization/entity associated or affiliated with or engaged by PNB MetLife, including reinsurers, claim investigative agencies, vendors and industry associations/federations, for the purpose of processing this claim, application and/or for providing subsequent services.

Declaration by Group Policy Holder

We confirm that the foregoing information including the details of the insured member stated above are true to the best of our knowledge and belief and our born out from our official records.

Signature of authorized signatory with Company seal of Master policy holder

Name and Designation: _____ Contact No.: _____ Date: _____

Part B:

1) Please provide bank account number and PAN No./ Form 60 for all the Nominees:

Particulars	Nominee 1	Nominee 2	Nominee 3	Nominee 4	Nominee 5
Name					
Bank Account Number					
IFSC Code					
PAN No./ Form 60					

2) Please provide the following details pertaining to Nominee/s for Life Insurance Benefit as per GPH records:

Sl. No.	Nominee Name	Relationship	Benefit Share in %	Address of Nominee

3) In case of death due to illness or unnatural cause require following:

Types of illness and date of diagnosis	
Details of treatment given and details of hospital where insured had undergone treatment	
Details of accident (for unnatural death)	
Name and address of hospital where postmortem was conducted	
Name and address pf police station to which accident was reported	

Declaration and authorization by Beneficiary

I/We, the above named claimant/s, do solemnly declare that the foregoing statements are true and agree that furnishing this form, or any other form supplemental there to, by the Company, shall not constitute an admission by it that there was any insurance in force on the life in question or a waiver of any rights or defense. Notwithstanding, any law, custom or usage, prohibiting the furnishing of secret information obtained during the medical treatment/investigation of member.

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 advisor or other institute to provide to PNB MetLife India Insurance Company Ltd, any of it 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 Insured Member, or any information that may be required concerning the health of the Insured Member including information relating to mental illness, use of drugs, use of alcohol, HIV(AIDS) and/ or sexually transmitted diseases. A Photostat copy of this authorization shall be considered as effective and valid as the original.

I/We hereby further consent, and authorize, PNB MetLife to use and disclose any of the personal and sensitive information of mine/our collected or available with PNB MetLife (whether contained in this statement/application or obtained otherwise) which may include KYC documents to any individual/organization/entity associated or affiliated with or engaged by PNB MetLife, including reinsurers, claim investigative agencies, vendors and industry associations/federations, for the purpose of processing this claim, application and/or for providing subsequent services.

Indemnity/Undertaking/Warranty and Representations by the Claimant in lieu of original policy bond and document

I irrevocably inure, acknowledge, represent and undertake to the Company that the original policy bond/documents are not pledge, mortgaged, assigned or otherwise created any adverse lien, title, interest over it either by the policyholder or by the legal heirs and I further undertake to destroy it as a null and void document post receipt of the full and final payment of the claim under the policy from the Company. I further undertake that the Company stands indemnified by me against all losses, claims whatsoever arising out of anything in relation to the dispensation of original policy document or the representations/warranties herein. I completely understand and agree with the Company that it shall stand conclusively discharged from all the obligations arising out of this policy/ies upon making the payment to me, nominee, legal heir or successor of the policyholder/life assured.

I hereby acknowledge and agree that any incorrect, false, or misleading or deficit information furnished by me may result in the rejection of claim or the recovery of claim proceeds with cost and compensation as the case may be apart from civil and criminal liability on me and my assets.

Signature of the Nominee of Insurance Claim

Particulars	Nominee 1	Nominee 2	Nominee 3	Nominee 4	Nominee 5
Name of Nominee					
Signature of Nominee					
Contact No.					
Date					

Declaration by Group Policy Holder

We confirm that, the Nominee/s mentioned in this form is/are as nominated by the employee for the purpose of vesting of his/her life Insurance benefits.

Signature of authorized signatory with Company seal of Master policy holder

Name and Designation: _____ Contact No.: _____ Date: _____