

## Employer Employee Death Claim Form

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

**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) Date of Death: \_\_\_\_\_ 10) Place and Cause of Death: \_\_\_\_\_

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

12) 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

- 13) Sum Assured: \_\_\_\_\_
- 14) PF Account Number of Insured Member: \_\_\_\_\_ (Mandatory for EDLI Claim)
- 15) Please confirm employment status of the employee as on date of death: Permanent  Contractual
- 16) Please confirm whether employee was actively at work as on date of joining: Yes  No

**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 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 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 for all the Nominees:

Particulars	Nominee 1	Nominee 2	Nominee 3	Nominee 4	Nominee 5
Name					
Bank Account Number					
IFSC Code					

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 of 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 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 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.

**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: \_\_\_\_\_

**Documents required**

- Original or Copy of Death Certificate issued by Municipal Authority/ Gram Panchayat duly attested by the Group Policyholder
- Details of nominee with bank details with copy of cancelled cheque leaf or pass book
- In case of Unnatural death (like Suicide, Accidental Death). Copy of FIR, Post Mortem Report and Police Inquest Report (duly attested by GPH) would be required
- ID and Address Proof of the Nominees attested by GPH

**Note:** Above document are required for registration purpose, Company may ask additional documents for processing of the claims