**EMPLOYER INFORMATION**

**NAME OF EMPLOYER:** **POLICY NO.**

**EMPLOYER ADDRESS:**

##### IMPORTANT: This form must be filled and signed by the POLICYHOLDER

**Information about the deceased**

 **NAME OF THE EMPLOYEE (DECEASED): MARITAL STATUS** **TYPE OF ID /** **ID NO.:**

**EMPLOYEE NO HOME PHONE NO. DESIGNATION NATIONALITY**

 **SEX**

 **DATE OF BIRTH BASIC SALARY**

**MALE**   **FEMALE**

 / /

**DATE OF JOINING THE COMPANY** **DATE OF JOINING IN THE SCHEME**  **LAST WORKING DATE**

 / /

 / /

 / /

 **DATE OF DEATH TIME OF DEATH PLACE OF DEATH**

 / /

**CAUSE OF DEATH**

**REPATRIATION EXPENSE DETAILS (IF APPLICABLE)**:

 **NAME OF DECEASED’S REGULAR DOCTOR? (IF ANY) SINCE WHEN?**

 / /

**DOCTOR’S ADDRESS**

 **DID THE DECEASED EVER CONSULT A SPECIALIST?**

 NO YES WHEN?

**Required Documents**

* Please attached the following documents with the claim form
* Death Certificate stating the cause of death,
* If the death is overseas, then death certificate must be attested by the relevant embassy / consular, provide a copy of approved leave
* Police report (if death was due to an accident).
* Medical / Hospitalization report with detailed diagnosis and cause of death (if death was due to sickness).
* Post-Mortem Report ( if it is legally required)
* Last Salary Certificate (or copy of Payroll confirming last salary paid to deceased)
* Clear copy of National Identity document or Passport with residence visa page for the deceased.
* Letter from Employer confirming that deceased was actively at work at the time of death.
* Copy of Repatriation Expenses invoices/receipts (if covered).
* *Please note that the company might request further documents as deem necessary*

 **DECLARATION**:

**I believe that the Deceased is the same person as the Life Insured under a Policy issued by <Insurer> and I authorize any hospital, institution or medical practitioner who has treated or examined the deceased to provide <Insurer> with any medical information it may request**.

**DATE SIGNATURE NAME & DESIGNATION WITH SEAL**