CLAIM INTIMATION FORM INDIVIDUAL LIFE POLICIES

Instructions for filling up the form

1. Please fill this form in BLOCK LETTERS using black or blue ink.
2. This form must be filled by the **CLAIMANT** only. If the Claimant does not understand the language, then the scribe should explain all the contents to the claimant and then he / she should also sign in the relevant place in this form. **The scribe should be known to the claimant well.**
3. **All the fields in this form must be filled. If any field is not applicable or not relevant, please mention "NA" or "NONE", but do not leave it blank and do not put a " - ".**
4. This form must be sent to "Claims Department", Kotak Mahindra Old Mutual Life Insurance Limited, 8th Floor, Godrej Colisum, Behind Everard Nagar, Sion (East), Mumbai- 400 022.
5. Please fill Annexure 1- Rider Claim Intimation Form **in addition** to this form if claim is for rider benefits under the policy.

Photograph of the Claimant (please affix signature across the photograph)

A. PARTICULARS OF THE AFFECTED PERSON

Mr/Ms/Title	Surname	First name	Middle name

Maiden Name / Any other name by which the Life Insured was ever known

Mr/Ms/Title	Surname	First name	Middle name

Complete Address

PERMANENT ADDRESS :

City / Town : ________________ State :

PIN CODE : ________________ ________________

CURRENT RESIDENTIAL ADDRESS :

City / Town : ________________ State :

PIN CODE : ________________ ________________

Date of Birth (DDMMYYYY)

OCCUPATION :

IDENTIFICATION MARK(s) :

DETAILS OF LIFE INSURANCE POLICIES

Details of ALL Life Insurance Policies [Kotak & other Companies] :

[attach a separate sheet if the no. of policies is more than 5]

Name of the Insurance Company and Branch	Commencement Date (DDMMYYYY)	Policy No.	Staus of Claim (Paid/ Rejected/ Pending)	Sum Assured (Rs.)

B. ASSIGNMENT DETAILS

Name of the person who has possession of the policy : ________________________________

Is the policy assigned? ☐ Yes ☐ No Has assignment been released? ☐ Yes ☐ No

Name & Address of the Assignee (Please attach a copy of the assignment agreement)

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CLAIM INTIMATION FORM INDIVIDUAL LIFE POLICIES

C. PARTICULARS OF CLAIMANT / POLICYHOLDER

Mr/Ms/Title	Surname	First name	Middle name

Maiden Name / Any other name by which the Claimant / Policyholder was ever known

Mr/Ms/Title	Surname	First name	Middle name

Complete Address

PERMANENT ADDRESS :	**CURRENT RESIDNETIAL ADDRESS :**

City / Town : ________________ **State :**
PIN CODE : ________________ ________________

City / Town : ________________ **State :**
PIN CODE : ________________ ________________

Date of Birth (DDMMYYYY)	**OCCUPATION :**
	OCCUPATION ADDRESS :

Relationship with Affected Person & No. of Years: ____________________________

Identification & Relationship Proof Document **[Photo ID Proof to be submitted alongwith this form]**

BANK DETAILS

Bank Name	Branch	Account No.	Complete Address of the Bank

PLEASE ATTACH A PHOTOCOPY OF YOUR BANK PASSBOOK SHOWING A/C.NO. AND HOLDERS' NAMES ALONG WITH PHOTO IDENTITY PROOF AND ADDRESS PROOF OF THE

In what capacity are you claiming? Nature of Title under which the claim for policy money / WOP is being made, viz

- ☐ Nominee
- ☐ Appointee
- ☐ Assignee
- ☐ Policyholder
- ☐ Legal Heir
- ☐ Executor
- ☐ Trustee
- ☐ Others (Please specify) ____________________

D. DETAILS OF CLAIM EVENT

Claim Event [Please tick against the appropriate box / boxes, as is applicable as per the policy terms]

- ☐ Natural death

Un-Natural Death due to :

- ☐ Accident
- ☐ Suicide
- ☐ Murder
- ☐ Others (please Specify)________________________________

- ☐ Critical Illness
- ☐ Permanent Accidental Disability of the Life Insured
- ☐ Death of the Premium Payer
- ☐ Permanent Accidental Disability of the Premium Payer

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CLAIM INTIMATION FORM INDIVIDUAL LIFE POLICIES

Date and Time of Claim Event	
Cause of Event (immediate and secondary)	
Place of Event (Residence, Hospital etc.- give details)	
Details of any past / previous illness(es) suffered during the life time of the Affected Person alongwith duration/ onset	
Description of ailment suffered by Affected Person at the time of claim event	
Duration/onset of these ailments	
Details of doctor to whom Affected Person first consulted for above-mentioned ailment (name, address and contact no.)	
If any other doctor was consulted for above ailment, details of that doctor (name, address and contact no.)	
Details of investigations carried out by the doctor(s). Please attach copy of all investigation reports and prescription papars	
Details of the last medical attendant(s) - name and addresses with contact numbers. (**Please submit Physician Statement)**	
Details of regular general physician/ family doctor of Affected Person - name, address and contact numbers. (**Please submit Physician Statement)**	
Details of earlier claim, if any, made for health or Life Insurance.	

E. Basic Claim Requirements

1. Please attach the hospital papers / last attending doctors papers alongwith this form.
2. Please attach all treatment / hospitalisation details for any illness / surgery / health disorder for the past 2 years
3. Please attach original death certificate issued by the municipal / equivalent authority [as per the laws of the nation] alongwith this form – in case of death.
4. Please attach original policy document(s) with this form.
5. Please attach attested FIR copy, attested Post Mortem Report copy and Driving Licence copy [for motor accidents] alongwith this form for unnatural deaths / accidental claim events.
6. Please attach Claimant Identification & Relationship Proof of the claimant with the Life Insured.
7. Please attach photo identity proof and address proof of claimant. For list of valid proofs, contact your nearest Kotak Life Insurance Branch / Your Life Advisor.

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CLAIM INTIMATION FORM INDIVIDUAL LIFE POLICIES

F. AUTHORISATION AND DECLARATION

Notwithstanding the provisions of any law, usage, custom or convention for the time being in force prohibiting any physician or Hospital or any other authority from divulging any knowledge or information acquired by him / her / them in attending upon or examining a person on the ground of secrecy, I hereby authorise any physician and any Hospital who has attended upon or examined or treated the aforesaid deceased life assured for any ailment or illness or any other authority to divulge any knowledge or information regarding the deceased's state of health which he / she / they may have acquired whether before or after the policy was issued by Kotak Mahindra Old Mutual Life Insurance Limited., to any of the authorised representatives of Kotak Mahindra Old Mutual Life Insurance Limited or at any of its offices or in any court of law.

DECLARATION BY THE CLAIMANT

I, ________________________________, do hereby; declare that the statements made herein above are true and complete in each and every respect. I understand that in furnishing claim forms, Kotak Life Insurance has not admitted liability or waived any of its rights.

Signed at …………………… this day of ………………………….. 20 ....

____

(Signature of Claimant)

Left Hand Thumb Impression	**Right Hand Thumb Impression**

Thumb Impression of Claimant [Not required if the claimant has signed this form alongside]

Details of the scribe

[Please fill, if the claimant has signed in a vernacular language or has affixed his / her thumb impression]

Full Name of the Scribe :
Date of Birth :
Complete Address :

Contact No. :

Signature of Witness : ___________________________________
Name of Witness :
Address :

G. FOR OFFICE USE ONLY

[To be filled by Branch Operations Executive / Life Advisor / Corporate Agent]

1.	Claim Intimation Form is filled up completely and nothing is left blank	☐ Yes	☐ No
2.	All documents as mentioned in this form are attached alongwith this form?	☐ Yes	☐ No
3.	All KYC documents are submitted by the claimant	☐ Yes	☐ No
4.	Claims Checklist has been filled and attached to claim intimation	☐ Yes	☐ No

Name of BOE / Life Advisor / Specified Person :
Signature :

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CLAIM INTIMATION FORM INDIVIDUAL LIFE POLICIES

ANNEXURE 1- RIDER CLAIM INTIMATION FORM

A. CRITICAL ILLNESS BENEFIT CLAIM

Claim Event [Please tick against the appropriate box / boxes, as is applicable as per the policy terms]

- ☐ Heart Attack (Myocardial Infarction)
- ☐ Cancer
- ☐ Stroke
- ☐ Coronary artery by-pass graft surgery (CABG)
- ☐ Kidney Failure
- ☐ Major organ transplant
- ☐ Aorta surgery
- ☐ Loss of Limbs
- ☐ Heart value surgery
- ☐ Major burns
- ☐ Blindness
- ☐ Paralysis

Details of Critical Illness :

Date of First Diagnosis of the Critical Illness (DDMMYYYY): ☐☐☐☐☐☐☐☐

[Attach complete hospitalisation papers and all past treatment details]

B. PERMANENT DISABILITY CLAIM

Type of PDB [please tick the appropriate box]

- ☐ Unable to use both hands at or above the wrist
- ☐ Unable to use both legs at or above the ankle
- ☐ Unable to use one hand at or above the wrist and one foot at or above the ankle
- ☐ Blind in both eyes
- ☐ Unable to earn an income from the date of the accident onwards from ANY work, occupation or profession [commensurate with his educational qualifications, training and experience]

Nature & Extent of Disability:

DATE OF ACCIDENT (DDMMYYYY) : ☐☐☐☐☐☐☐☐

[Attach complete hospitalisation papers and all past treatment details. Also attach FIR Copy / Driving Licence Copy, if applicable]

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CLAIM DISCHARGE FORM INDIVIDUAL LIFE POLICIES

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I Mr. / Ms. ____ resident of (Complete Current

Residential Address) ____

____

____

hereby declare and confirm that I am the beneficiary in the capacity of Policyholder/ Nominee/ Assignee/

Appointee/ Trustee/ Legal Heir of the policies mentioned below of the Life Insured Mr./ Ms.___________

____.

I hereby acknowledge receipt from Kotak Mahindra Old Mutual Life Insurance Ltd. sum of Rs.

___________________ Rupees (in words) ____

____ vide cheque no. _________________ dated __________

drawn on _____________________________________ Bank _________________ Branch towards full

and final settlement of Claim under Policies mentioned below.

Policy No.	Amount (Rs.)	Discreption (basic sum assured or rider sum assured)

I hereby discharge Kotak Mahindra Old Mutual Life Insurance from it's liability under the said policy (ies).

Revenue

Stamp

Signature of Claimant

Signed at _______________ on ___________this day of _____________20_______.

(Place) (Date)

Signature of Witness:

Name of Witness:
Address of Witness:

This is just an intimation letter and should be followed by relevant completed claim forms along with all supporting documents required to process the claim at the earliest. **This is not admittance of the claim.**