

GROUP LIFE DISABILITY / DEATH  
CLAIM FORM



Name and address of the assured: \_\_\_\_\_

Name of the disabled/deceased person: \_\_\_\_\_

Occupation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

(Attach evidence if not furnished earlier)

Date of appointment: \_\_\_\_\_ Date of confirmation: \_\_\_\_\_

Last day duty attended: \_\_\_\_\_ Date of disability/death: \_\_\_\_\_

Time: \_\_\_\_\_ Place: \_\_\_\_\_

In the event of death, please specify the exact cause of death and whether it was due to accident, suicide or homicide and describe briefly: \_\_\_\_\_

IN THE EVENT OF DISABILITY, PLEASE ANSWER THE FOLLOWING:

a) Exact cause of disability: \_\_\_\_\_

b) Nature of disability: \_\_\_\_\_

c) Date of disability being declared: \_\_\_\_\_

d) Extent of disablement: \_\_\_\_\_

Confined to bed: From: \_\_\_\_\_ To: \_\_\_\_\_

Confined to house: From: \_\_\_\_\_ To: \_\_\_\_\_

e) Present state of incapacity: \_\_\_\_\_

f) Name and address of the hospital; if any: \_\_\_\_\_

g) Name and address of doctor in attendance, if any: \_\_\_\_\_

**Note:** If answers to (f) and (g) are 'Yes' please submit the prescribed Medical Certificate duly completed.

Leave granted to the disabled/deceased, if any, during the last three years (type of leave and duration):

Salary: \_\_\_\_\_ Amount of Insurance: \_\_\_\_\_

Whether the disabled/deceased was your employee until the date of disability/death: \_\_\_\_\_

Please mention S. No. of the list where the name of the disabled/deceased appears: \_\_\_\_\_s

In the event of death, please furnish name and address of Legal Heir of the deceased and relationship: \_\_\_\_\_

**I hereby declare that the particulars mentioned above are true and correct.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Place: \_\_\_\_\_

Designation: \_\_\_\_\_