Max Life Insurance Company Ltd.
90 A, Sector-18, Udyog Vihar, Gurgaon-122015, Haryana
Phone Number- 0124-4219090, Extn-9699, Toll Free- 18001805577
Email- claims.support@maxlifeinsurance.com

Application form for Death Claim-Claimant's Statement – Gratuity

(To be completed, signed and stamped by the policyholder. All the answers must be clear & unambiguous.)

I. Claimant's Information	
1A) *Name of the Group Policy Holder:	1B) *Group Policy Number:
2A) *Capacity as a Claimant (Relationship):	2B) *Sum Assured:
II. Information of the deceased (Member Insured)	
3A) *Full Name of the Deceased:	3B) *Membership Number: *Employment Number:
3C) * Please specify the date of coverage commencement: * Was the member actively at work on the date of coverage commencement? Yes_____No_____	
4) Place of Death:	5) *Date & Time of Death:
6) *Date of Birth:	7) *Gender: ☐ Male ☐ Female
8) Deceased's Residential Address:	
9) Deceased's Job Profile/ Designation at the time of death:	
10A) *Immediate cause of Death:	10B) Duration of Last Illness**:**
11A) *Date of Joining:	11B) *Last Date at work:

12) *Nature and Duration of leave availed in the last 2 years:

Nature of Leave (Casual, Medical, Earned, Privilege)	Effective Date-Commencement	Effective Date-resuming duties	Total Duration of Leave availed

If the group size is less than 200, then please provide sick leave records for period of 6 months immediately preceding the date of entry:

Nature of Leave (Sick Leave)	Effective Date-Commencement	Effective Date-resuming duties	Total Duration of Sick Leave availed

Fields (13-16) to be completed only if the cause of death is accident.

13) Date & Time of Accident:	14) Place of Accident:
15) Details of Accident (Type of Accident / Police Station & FIR No):	
16) Post-Mortem/Autopsy been done: Yes____ No ____	

Fields (17-19) to be completed only if the cause of death is medical.

17) When did the deceased first take treatment for the illness, which eventually caused his death?	
A. Date & Type of Illness:	B. Contributory Cause of Death (if any):
18) Name of the Doctor(s) (with Contact details) consulted during the last illness: Name: Tel Nos. (with STD Code):	

19) Name & Addresses of the Doctor(s) who treated him during the last three years & the ailments cured by them:

Date of Consultation	Name & contact # of the Doctor	Reasons for Consultation

III. Declaration And Authorization

I/We, the above-named claimant(s), do solemnly declare that the foregoing answers and statements are true in all respects, and further agree at the furnishing of this form, or any other form supplemental thereto, to the Company, shall not constitute an admission by the Company that there was any insurance in force on the life in question or a waiver of any rights or defence. Notwithstanding, any law, custom or usage, prohibiting the furnishing of secret information obtained during the medical treatment / investigation of Life Insured, 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 adviser or other institute to provide to MAX LIFE 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 deceased, or any information that may be required concerning the health of the deceased (Life Insured) including information relating to mental illness, use of drugs, use of alcohol, HIV(AIDS Virus) and /or sexually transmitted diseases. A Photostat copy of this authorization shall be considered as effective and valid as the original.
The Policy Holder shall hold all benefits received under this Policy UPON TRUST for the benefit of the person(s) to whom the benefits are payable in accordance with the Rules and the Policy Holder shall have no beneficial interest in the same.

***Authorised Signatories of the Group Policy Holder**

Signature:

Name & Designation:
Company Seal

***Witness- Mandatory**

Signature:

Name:
Address:

Dated this_____day of _____ month in the year _____

Ver 1.1 June 05, 2012

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Electronic Funds Transfer- Mandate form

I _____ is a Nominee/Policyholder in Policy Number_____(Nominee Name) in the Name of _____hereby request Max Life Insurance Co. Limited to make Claim payments directly to my bank account as per detail given below.

Account Holder Name: _____

Type of Bank Account: _____

Bank Account Number: _____

Branch Address :_____

_____

MICR code :_____

IFSC code (Indian Financial Security code):_____

Nominees Signatures: _____

Date:

Bank Verification - Name of Bank:

Branch address & stamp:

Please attach a copy of cancelled cheque along with this form.