pnb MetLife
Milkar life aage badhaein

INDIVIDUAL DEATH CLAIM FORM

For Official Use Only
Branch Name: _____ Branch Code: _____
Employee Name: _____
Employee Code: _____ Sign: _____
Date: D D M M Y Y Y Y Time: ☐ On or Before 3PM ☐ After 3PM

Photograph of Claimant

DOCUMENTS TO BE SUBMITTED

Mandatory Documents	Additional documents* to be submitted
1. Copy of valid death certificate issued by local authority 2. Doctor's Certificate (From the family physician or treating doctor) preferably in the standardized PNB MetLife format 3. Current address proof of the nominee 4. PAN Card or Form 60 of the nominee 5. Photo identity proof of the nominee 6. Cancelled cheque / Copy of bank passbook 7. Authorization letter from the claimant in case the claim intimation is received through third party for claims received at the branch/GPH 8. Legal heir/Succession certificate in case of absence of nominee Note: - Please mask first 8 digits of Aadhaar number if Aadhaar Card is submitted as KYC proof with the request	**Natural death/ death due to illness** 1. Complete Medical records (Admission notes & Discharge / Death summary & Test / investigation reports etc.) for any treatment taken in past or at the time of death **Accidental Death** 1. Copy of FIR, Panchnama, Inquest report, Postmortem report 2. Obituary/ Newspaper cutting (if available) 3. Viscera / Chemical analysis report (if applicable) 4. Final police investigation report

**PNB MetLife reserves the right to call for any additional documents /evidences apart from the given below, if required.*

*SECTION A - POLICY DETAILS

Policy Number(s): _____
(Please mention all policy numbers with PNB MetLife India Insurance Co. Ltd)

*SECTION B - DETAILS OF LIFE ASSURED (LA)

Name of Life Assured: ☐ **Mr.** ☐ **Ms.** F I R S T _____ M I D D L E _____ L A S T _____
Father's Name: F I R S T _____ M I D D L E _____ L A S T _____
Date of Death: D D M M Y Y Y Y
Place of Death: ☐ Hospital* ☐ Clinic* ☐ Residence ☐ Office ☐ Other (Please specify) _____
*If hospital/ clinic is selected, please mention hospital/ clinic name _____
Family Doctor: Name: _____
Registration No.: _____ Contact No.: _____ PAN No./ Form 60: _____
Last treated/attended Doctor: Name: _____
Registration No.: _____ Contact No.: _____
Last Employer details (If applicable):
Name of the Company: _____ Name of contact person: _____ Last working day of Life Assured: D D M M Y Y Y Y
Nature of work and designation: _____
Nature of Death: ☐ Natural ☐ Suicide ☐ Accident ☐ Murder ☐ Medical (If Medical, pls. specify the illness) _____
Cause of Death: _____

SECTION C - NATURE OF ILLNESS AND HABIT OF THE INSURED

			Date of diagnosis of illness
☐ Hypertension	☐ Diabetes	☐ Heart disease	
☐ Kidney disease	☐ Cancer	☐ Other _____	
☐ Smoking	☐ Tobacco	☐ Drugs	If yes, Duration of Consumption _____ & Quantity Consumed
☐ Asthma	☐ Tuberculosis		

SECTION D - OTHER INSURANCE DETAILS: (LIFE/MEDICLAIM/HEALTH)

Policy No.	Company Name	Sum Assured	Status (Active/Lapsed/Applied/Matured)

SECTION E - DETAILS OF CLAIMANT

Claimant Name: ☐ **Mr.** ☐ **Ms.** F I R S T _____ M I D D L E _____ L A S T _____
Date of Birth: D D M M Y Y Y Y

Address:

LANDMARK | CITY/TOWN/VILLAGE
DISTRICT | PIN/POSTCODE | STATE/UTCODE

Contact No.: OFFICE: RESIDENCE: MOBILE:

☐ (Tick to get your claims related update on your WhatsApp)

Office &/ or Personal Email id:

Relation with Life Assured: ☐ Spouse ☐ Children ☐ Parents ☐ Others (Please specify) _____

Claimant's Title: ☐ Nominee ☐ Executor ☐ Trustee ☐ Appointee ☐ Employer ☐ Assignee ☐ Beneficiary

Claimant's PAN details: ☐☐☐☐☐☐☐☐☐☐ or Form 60 ☐

Politically exposed person: ☐ Yes ☐ No

US Person: ☐ Yes ☐ No (If Yes, please fill FATCA / CRS Questionnaire)

SECTION F- CLAIMANT NEFT MANDATE/ BANK ACCOUNT DETAILS

Account No.: _____

Account Holder Name: _____

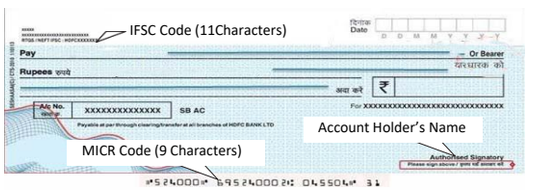
Bank Name & Branch: _____

Account Type: ☐ Savings ☐ Current ☐ NRO ☐ NRE#

IFSC: _____ MICR: _____

Payout option: ☐ Lump sum ☐ Regular Payment ☐ Annuity

(Options are subject to applicable Terms & Conditions of the Policy.)



SECTION G- NAME, ADDRESS AND CONTACT DETAILS OF ALL DOCTORS / HOSPITALS WHERE THE LIFE INSURED WAS TREATED WITHIN THE LAST 5 YEARS PRECEEDING THE DEATH

Name of Doctor/ Hospital	Address and Contact Details	Disease /Condition Treated For	Treatment Dates (From- To)

*SECTION H- DECLARATION AND AUTHORIZATION

I/We, the above-named Claimant(s), do solemnly declare that the above answers and statements are true in all respects, and I/ we further agree that in furnishing claim form PNB MetLife has not admitted any liability or waived any of its rights. I/ We understand and agree that the submission of this form does not mean that the request will be processed. I/ We understand that any payout under the policy shall be strictly in accordance with the policy terms and conditions. Any payment shall be subject to realization of the last renewal premium payment. A photocopy of this declaration shall be considered as valid and effective.

I/We hereby authorize the physicians/doctors or hospitals, medical centers, who has attended upon or examined or treated the aforesaid deceased person/insured for any ailment or illness or other Insurance Companies which issued policies to the aforesaid deceased person/insured, present/ past employers or business associates of the life insured, Birth and Death Registrar, Diagnostic centers wherein the life insured underwent personal/ official/ insurance related medical tests, to divulge or share any knowledge or information or documents regarding the deceased's state of health or other details which he/they may have acquire whether before or after the policy was issued by PNB MetLife. A Photocopy 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 or obtained otherwise) which may include KYC document to any individual / organization / entity associated or affiliated with or engaged by PNB MetLife including reinsures, claim investigative agencies, vendors and industry associations/federations, for the purpose of processing this claim and/or for providing subsequent services.

Indemnity/Undertaking/Warranty and Representations by the Claimant in lieu of original policy bond and document

I irrevocably inure, acknowledge, represent and undertake to the Company that the original policy contract is not pledged, mortgaged, assigned, or otherwise created any adverse lien, title, interest over it either by the policyholder or by the legal heirs and I further undertake to destroy it as a null and void document post receipt of the full and final payment of the claim under the policy from the Company. I further undertake that the Company stands indemnified by me against all losses, claims whatsoever arising out of anything in relation to the dispensation of original policy contract or the representations/warranties herein. I completely understand and agree with the Company that it shall stand conclusively discharged from all the obligations arising out of this policy/ies upon making the payment to me, nominee, legal heir, or successor of the policyholder/life assured. I hereby acknowledge and agree that any incorrect, false, or misleading or deficit information furnished by me may result in the rejection of claim or the recovery of claim proceeds with cost and compensation as the case may be apart from civil and criminal liability on me and my assets.

Date: D D M M Y Y Y Y

Place: _____

SIGN HERE

Signature of Claimant

DECLARATION TO BE MADE BY A THIRD PERSON

The Policyholder has affixed his/her thumb impression/has signed in vernacular/has not filled the application. I hereby declare that the content of this application form has been explained to the Policyholder in _____ language and have truthfully recorded the answers provided to me. I further declare that the Policyholder has signed/affixed his/her thumb impression in my presence.

Name of the Declarant: _____ Claimant relation with Declarant: _____

Address: _____ Contact Number of Declarant: _____

Date: D D M M Y Y Y Y

Place: _____

SIGN HERE

Signature of Third person

Terms and Conditions:

1) The submission of the filled-up claim form, along with the required mandatory documents, is not to be construed as an admission of liabilities of our Company under the policy. No agent/intermediary has been or is authorized to admit any liabilities on behalf of the Company.
2) Early submission of this form along with the required mandatory documents, as provided below, will enable us to process your claim faster. PNB MetLife shall not be responsible for any delay in the processing of the claim on account of the submission of incomplete claim form and/or non-submission of the mandatory documents.

Important Note: In case of any demand or favor asked by anyone including a company representative towards claim processing or settlement, the same should not be entertained and must be reported to the company immediately on the company's Email id: claimshelpdesk@pnbmetlife.com

INSTRUCTION FOR FILLING UP THE FORM

IMPORTANT INFORMATION (Please read before filling in the form)

1. The form should be filled in by the claimant only. In case the claimant is a minor, the guardian/appointee may fill in the form.
2. Claims under multiple policies may be registered by filling in a single form & providing all applicable policy numbers.
3. In the case of more than one claimant, separate forms need to be filled for each claimant.
4. Please read the declarations carefully and the claimant should sign the claim form in the same manner as you normally sign your cheque.
5. Claim is payable subject to fulfillment of all terms and conditions of the policy.
6. No fee or commission should be paid to anyone to process this claim.
7. Make sure your address, phone numbers and email ID are current and active as the correspondence will happen through this only.
8. Asterisk (*) refers to mandatory information.

CUSTOMER ACKNOWLEDGEMENT COPY-INDIVIDUAL DEATH CLAIM FORM

Policy No.: _____ Claimant Name: _____

Branch Name / Intimation Number: _____ Claimant Client ID: _____

Employee Name: _____ Date: _____

Employee Signature: _____ Employee Code: _____

IRDAI Registration No. _____

Branch Stamp

LIST OF OFFICIALLY VALID DOCUMENTS – IDENTIFY AND ADDRESS PROOF (Please tick any one document submitted)

☐ Voter ID Card ☐ Valid Passport ☐ Valid Driving License

☐ Aadhar Card* ☐ NREGA card (National Rural Employment Guarantee Act)

Please note PAN/Form 60 is mandatory for all cases.

*I voluntarily provide my consent to use my Aadhar to conduct identity check towards KYC compliance by PNB MetLife Insurance Co. Ltd

NOTE: CLAIMANT NEFT MANDATE/ BANK ACCOUNT DETAILS

- A cancelled personalized cheque with the account no. and IFSC should be submitted along with the NEFT mandate. If the cheque is not personalized, a latest bank statement or copy of passbook (where account number and IFSC is mentioned) needs to be submitted with the mandate.
- This mandate, upon processing, will override any of the previously tagged NEFT mandates for all policies, held by the client with PNB MetLife Insurance Co. Ltd.
- In case of NEFT failure or any further requirements pending on the mandate, payout will be kept on hold till fresh NEFT mandate is received. Intimation will be sent to you for the same.

  #Refund to NRE account (full or proportionate) will be subject to a ratio of premium(s) paid through NRE Account. Please submit a Bank Statement or Bank Confirmation letter as evidence for premium(s) paid through NRE account.

  In case of a proportionate payout, please provide two NEFT mandates i.e. for the NRE account and Non-NRE account.

PNB MetLife India Insurance Company Limited Registered office: Unit No. 701, 702 & 703, 7th Floor, West Wing, Raheja Towers, 26/27 M G Road, Bangalore -560001, Karnataka. IRDA of India Registration number 117. CI No. U66010KA2001PLC028883, Call us Toll-free at 1-800-425-6969, Website: www.pnbmetlife.com, Email: indiaservice@pnbmetlife.co.in or write to us at 1st Floor, Techniplex -1, Techniplex Complex, Off Veer Savarkar Flyover, Goregaon (West), Mumbai – 400062. Phone: +91-22-41790000, Fax: +91-22-41790203

BEWARE OF SPURIOUS / FRAUD PHONE CALLS: IRDAI is not involved in activities like selling insurance policies, announcing bonus or investment of premiums. Public receiving such phone calls are requested to lodge a police complaint.