



DEATH CLAIM INTIMATION FORM INDIVIDUAL POLICY CLAIMS

- Passport Voter Identity Card Driving License Electricity Bill
 Ration card Bank Statement /Passbook updated till the previous month
 Aadhar Card Valid Lease Agreement with rent receipt of recent 3 months
 Telephone Bill Any other (Kindly Specify) _____

State: _____ Pin code: _____

Telephone: S T D L A N D L I N E Mobile No: _____

Relationship with Insured Person: _____ EMAIL ID: _____

Bank A/c Details: Bank Name: _____ Branch Name & Address: _____

A/C No.: _____ IFSC Code: _____

I HEREBY GIVE MY CONSENT TO DIRECT CREDIT / NEFT / RTGS CLAIM AMOUNT IN MY ACCOUNT: YES NO

3. Payment Option Details:

Kotak Smart Advantage Plan (107L043V01) / Kotak Head start Future Protect (107L037V01/ 107L038V01) / Kotak Long Life Secured Plus (107L044V01) (Please tick as applicable)**

Lump Sum Installment

For Kotak Premier Endowment Plan 107N079V01, kindly fill up the separate settlement option form specific to the plan.

***Kotak Retirement Income Plan(All variants except KRIP with Cover)** (107N013V01 / 107N014V01 / 107L031V01 / 107L033V01 / 107L032V01 / 107L024V01 / 107L026V01 / 107L025V01) / ***Kotak Secure Retirement Plan (107L049V01) / *Kotak Guaranteed Pension Builder (107L057V01) / *Kotak Second Innings Plan (107L052V01 / 107L052V02)** (Please tick as applicable)

Entire Amount as Lump Sum Entire Amount as Annuity Part as Annuity part as Lump Sum

*I further declare that I will bear any tax liability accruing to me on account of taking the full refund of the amount instead of purchasing an annuity.

Prevailing tax laws will be applicable during the payment of the claim.

4. Basic Details of Insured Person:

Name (Full Name): _____

Maiden Name (Full Name): _____

Date of Birth: D M Y Y Y Y Qualification: _____

Occupation: Employed Self Employed Others (Specify) _____ Income: _____

Address: (PERMANENT) _____ (CURRENT) _____

State: _____ Pin Code: _____ State: _____ Pin Code: _____

5. Employment Details of Insured Person:

Last Business / Employer Name: _____

Address (With landmark): _____

Nature Of Work: _____ Designation: _____ Last Working Day: _____

This is just an intimation of Claim to the Company. This intimation is not admittance of the Claim by the Company.

→ Intimation



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EMAIL ID		Contact No (Landline / Mobile)	
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6. Details of Death of Insured Person:

Date of Death	DATE :	TIME :
Place of Death (Hospital, Home, Any other place)		
Type of Death (PLEASE TICK).	NATURAL <input type="checkbox"/>	ACCIDENTAL <input type="checkbox"/>
	SUICIDE <input type="checkbox"/>	MURDER <input type="checkbox"/>
	OTHERS <input type="checkbox"/>	
Cause of Death and Event Leading to Death		
Doctor / Hospital Contacted at the time of Death		
How Long was the Insured Person suffering from these symptoms		
Details of Doctor / Hospital Contacted first		

7. To be Filled in case of Unnatural Death (Kindly elaborate the specific unnatural claim event e.g. accidents, burns etc):

Details of Unnatural Death	
Details of the Doctor / Hospital contacted	

8. Details of Past History of Health / Habits of Insured Person

Nature of medical condition / habit (Please tick the relevant box)	Duration / First Date of Diagnosis	If yes, give details (Kindly attach all medical documents)
<input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes		
<input type="checkbox"/> Heart Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Cancer		
<input type="checkbox"/> Respiratory Disease		
Any other ailments / disorder/surgery /hospitalisation		
<input type="checkbox"/> Alcohol <input type="checkbox"/> Smoking <input type="checkbox"/> Tobacco <input type="checkbox"/> Narcotics in any form		

9. Details of Family Physician: Name of Clinic / Hospital:

Address:	
Telephone	S T D L A N D L I N E Mobile No.

EMAIL ID	
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10. Particulars of Other Life Insurance Policies [PLEASE MENTION DETAILS OF EVERY POLICY HERE]

Name of the Company	Policy No	Risk Commencement Date	Sum Assured	Status of Claim (Paid / Rejected / Pending)

11. Authorization & Declaration

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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 authorize 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 authorized representatives of Kotak Mahindra Old Mutual Life Insurance Limited or at any of its offices or in any court of law.

I, _____, do hereby; declare that the statements made herein above are true and complete in each and every respect. I understand that any incorrect or incomplete or misleading information in this form shall affect the claim settlement process and the decision of the Company. I agree to assist the Company in Claims Investigation. I also understand that in furnishing claim forms, Kotak Life Insurance has not admitted liability or waived any of its rights.

**** Note: "The company cautions against payment of any charges/monies as against claim processing fees to any authorized/unauthorized agency/person claiming the same. Company does not charge any fees for claims process and instructs any such action to be brought to its notice."*

Signed at: _____ **Date:** ____/____/____ **Signature / Thumb Impression of the Claimant** _____

Witness Details:

Name of Witness: _____ Contact No. : _____
Address: _____ Relationship with claimant: _____

Signed at: _____ **Date:** ____/____/____ **Signature of Witness:** _____

12. 12. Authorization to Company Representatives to Contact the Claimant & Family

I, Mr. /Mrs. /Ms _____, having _____ (Mobile number) _____ (Landline) _____ (email id) have applied for a claim under the aforesaid insurance policy(ies) of Kotak Life Insurance (Company), hereby authorize the Company and any of its representatives to make calls / SMS's / emails or personal visits for documentation / requirement or any other enquiry in relation to the aforesaid claim.

I also undertake that for such enquiry calls / SMS's in relation to the aforesaid claim, made by the Company and its representative, I shall not lodge a complaint for violation of TRAI guidelines on unsolicited phone calls and SMS's.

Signed at: _____ **Date:** ____/____/____ **Signature / Thumb Impression of the Claimant** _____

Witness Details:

Name of Witness: _____ Contact No. : _____
Address: _____ Relationship with Claimant : _____

Signed at: _____ **Date:** ____/____/____ **Signature of Witness:** _____

[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: _____ Relationship with Claimant : _____
Contact No. : _____ Complete Address : _____
Signed at: _____ **Date:** ____/____/____ **Signature of the Scribe:** _____