



STATEMENT – DEATH CLAIM – CORPORATE GROUPS

Name of the Company : _____

Policy Number : _____
 (*For official Use Only)

PART 1 – INFORMATION REGARDING DECEASED MEMBER

Name of The Deceased:
Employee Code:
Date of Commencement of Policy:
Date of Member Joining the insurance scheme:
Basic Cover Amount:
Rider Cover Amount:
Date of Birth:
Address:
Telephone Number:
Designation at the time of Death:
Service as on date of Death : _____ Years _____ Months _____ Days

Place of Death:			
Date of death:		Exact Time of death:	AM/PM
Duration of last illness:			
Exact Medical Cause of Death:			
Last Occupation, Address & Tel. Nos.:			
Name, Address & Tel. Nos. of doctor/ hospital certifying death:			

PART 2 – DOCTOR INFORMATION

Please complete the following showing the doctors consulted during the last 3 years.

1) Name of Doctor / Hospital Address & Tel. Nos.:	
Date or Dates of consultation:	
Nature of consultation:	

PART 3 – CAUSE OF DEATH

Please complete the relevant section:

A = Illness B = Accident

Section A - Illness

Name, address & Tel. Nos. of last attending Doctor	
Details of last illness:	
Names and addresses of relatives or other persons present at the time of death:	

Section B – Accident

How did the accident occur?	
1. Place of accident:	
2. Names, Addresses & Tel. Nos. of other persons involved (if available)	
3. Date and time of admittance to hospital:	
4. Name, Address & Tel. Nos. of hospital:	
5. Names, Address & Tel. Nos of police station where reported:	
6. Name of police officers who conducted investigations:	
7. Details of their findings (Please send copy of report if available):	

PART 3 – Bank Account Details for Direct Transfer Of Funds

Name Of The Bank	
Bank Account No.	
Bank Branch Name	
Bank Branch Code	
Nature of Account	<input type="checkbox"/> Savings <input type="checkbox"/> Current
NEFT Code	
IFSC Code	

PART 4 – DECLARATION

I/We _____ do hereby declare that this statement made hereinabove is true in each and every respect.

I/We agree to provide and furnish details and reports as and when required by SBI Life Insurance Co. Ltd. for processing this claim

Declared at: _____

Signature of the Authorised Signatory : _____

Name in Block Letters: _____

Designation: _____

Address: _____

Telephone number: _____

Date: _____

Stamp/Seal of the Company :

SBI Life Insurance Co. Ltd.

Corporate Office: Gr. Floor, Turner Morrission Bldg, G. N. Vaidya Marg, Fort, Mumbai – 400 021. Ph.: 56392000, Fax: 91 22 56392058

PART 5 – DOCUMENTS

Please provide the following original documents. If not provided, please state the reasons therefore.

In case of Natural Death / Death due to Illness

- Death Certificate Issued by appropriate Authority
- Age Proof
- Medical Certificate of Cause of Death.
- Declaration of Good Health Signed by the Member
- Hospital Records and Past medical reports of the Member

In case of Accidental / Unnatural Death

- Death Certificate Issued by appropriate Authority
- Age Proof
- Copy of FIR
- Copy of Police Panchmama Report (On the spot investigation report)
- Copy of Police Inquest Report (On the body investigation report)
- Copy of Postmortem Report.
- Declaration of Good Health Signed by the Member

*** Company reserves the right to call for any other document other than the ones mentioned above at its discretion.**