



DEATH CLAIM FORM - GROUP LIFE & INDIVIDUAL LIFE

CLAIM FORM :

GROUP LIFE

INDIVIDUAL LIFE

Form Completion Instruction:

- 1) This form may be completed by those having a claim benefits as a person nominated by the Policy Holder, Guardian, Assignee, Trustee or a successor
- 2) Please fill the form with single pen without omissions / deletions
- 3) Please complete the form with legible handwriting, incomplete form may cause delay in processing of claim benefits
- 4) This form should be duly attested by notary public, Nazim of a union council or above, executive of TPL Life Insurance Ltd. or class 1 officer of the federal/provincial government.

CHECKLIST OF DOCUMENTS REQUIRED:

- 1. Claimant Statement
- 2. Physician Statement
- 3. CNIC - Deceased
- 4. Death Certificate - Hospital
- 5. Death Certificate - NADRA
- 6. Treatment Records

Additional Requirements for Individual Life:

- 1. Assignment Letter
- 2. Original Policy Documents
- 3. Copy of Passport - Deceased & Claimant (if living abroad)
- 4. CNIC - Nominee

Additional Requirements for Group Life:

- 1. Salary Record
- 2. Attendance Record

Additional Requirement, if Accidental Death:

- 1. Copy of Autopsy
- 2. Copy of FIR
- 3. Newspaper article covering the accident
- 4. Medico Legal Report, if any

*In order to validate the claim, TPL Life Insurance Limited reserve the right to ask for further requirements, if deemed necessary.

CLAIM FORM A: INFORMATION ABOUT CLAIMANT / POLICY HOLDER

(To be completed by the claimant)

Name of Company / Claimant: _____

If claiming for individual life, please provide below information:

Father's / Husband's Name : _____
 Relationship with Deceased : _____ D.O.B : _____
 Gender : _____ Contact No. : _____
 CNIC : _____ Email ID : _____
 Claiming as: Nominee Beneficiary

CLAIM PAYMENT INFORMATION:

Payment Through : _____ Cheque / IBFT
 Name: _____ Account No.: _____
 Bank Name: _____ Branch Name: _____
If it is through cheque:
 Title of Cheque _____
 Amount of Claim: _____

INFORMATION ABOUT DECEASED

(To be completed by the claimant)

PERSONAL DETAIL	OCCUPATIONAL DETAIL
Name : _____	Employee ID : _____
Father / _____	Occupation: _____
Husband's Name : _____	Designation: _____
Gender: _____	Nature of Work : _____
Marital Status: _____	Date of Joining : _____
CNIC : _____	Annual Salary (PKR): _____
D.O.B : _____	Employer Contact No. : _____
Correspondence Address: _____	

Deceased covered with some other insurance company? (If Yes, provide detail)

Sr. No.	Name of Company	Policy No.	Issuance Date	Address and Contact No.
1				
2				
3				

EVENT DETAILS

Type of Death: _____ Natural / Accidental _____ Date of Death: _____

Time of Death: (_____ : _____) AM/PM _____ Place of Death: _____

Duration of Illness: _____ DD / MM / YYYY TO _____ DD / MM / YYYY _____

Illness complaint:

Date of Complaint	Details about complaint

Treatment details taken prior to death:

Sr. No.	Name of Hospital / Doctor Treated	Complaint About	Treatment Duration	Contact No.	Correspondence Address
1					
2					
3					

DECLARATION: I/We, as a claimant, hereby declare that the information provided in the form are true and complete to the best of my/our knowledge, belief, and record. I also hereby authorize TPL Life Insurance Limited in order to seek information from any doctor, hospital, laboratory, any other organization or person that has any record information or acknowledge of health/treatment and from any other Insurance / Takaful company to which a proposal has any time been made, and the giving of such information.

Claimant Signature
 (For Group Life, need duly stamped)

Date of Statement

Countersigned By:

Designation & Place of Signature

Date of Statement

* This statement must be countersigned by any of the following: notary public, Nazim of a union council or above, executive of TPL Life Insurance Ltd. or class 1 officer of the federal/provincial government.

CLAIM FORM B: PHYSICIAN STATEMENT

(To be completed by the Physician)

DECEASED INFORMATION:

Deceased Name: _____
Father/ Husband's Name: _____
CNIC #: _____ DOB: _____
Address of Deceased: _____

EVENT INFORMATION:

Date of Death: _____ Time of Death: (____ : ____) AM / PM
Place of Death : _____ Type of Death : Natural / Accidental
Name of Hospital (If died in hospital): _____
Interval between onset and death: (____) Days
Cause of Death:

Primary Cause:

Secondary Cause:

Any other disease / illness deceased is suffering from but not leads to death? :

PAST MEDICAL HISTORY:

First Complaint about current illness: _____ DD / MM / YYYY

Last Complaint about current illness: _____ DD / MM / YYYY

Prior to current illness, is the deceased in a regular consultation with you?

Yes / No

If yes, please provide details:

Have you referred the deceased any other physician or hospital for any treatment?

Yes / No

If yes, please provide following details:

Sr. No.	Name of Physician	Complaint About	Treatment Duration	Contact No.	Correspondence Address
1					
2					
3					

IF ACCIDENTAL DEATH / SUICIDE:

Date of Accident: _____

Time of Accident: (____ : ____) AM/PM

Describe event in detail:

Investigation held?	Yes / No	(If yes, please attach findings)
Autopsy Performed?	Yes / No	(If yes, please attach report)

DECLARATION:

I _____ medical attendant of the life insured _____ do hereby declare that to the best of my knowledge and belief the information given herein are true and complete.

Signature & Duly Stamp with date:

TPL Life Insurance Limited

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