pnb MetLife

Claimant Statement for Death Claim – Form A

The Claimant statement form must be filled by the claimant / beneficiary appointee / legally entitled person under the policy
The Form is to be filled in one color by one person in single ink only
All documents required to process the claim should be sent to "Claims Entity" mentioned in the page below
All supporting documents to be self-attested by nominee

Documents to be Submitted	
Mandatory Documents	**Additional documents* to be submitted**
1. Copy of death certificate issued by local municipal authority 2. Doctor's Certificate (From the family physician or treating doctor) 3. Original policy document 4. Current address proof 5. Photo identity proof 6. Cancelled cheque / Copy of bank passbook 7. Authorization letter from the claimant in case the claim intimation is received through third party	**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.*

1. POLICY NUMBER/S______________________________

2. DETAILS OF THE CLAIMANT

Name: ______________________ Date of Birth: D D M M Y Y Y Y Gender: ☐ Male ☐ Female

Relationship with Life Insured: ______________ Mobile / Landline number: ______________

Current Address: ______________________________

City: ______________ State: ______________ PIN Code:______________

Email ID: ______________

PAN: ______________ Aadhaar number: ______________

3. BANKING DETAILS

Bank Account No.: ______________Account holder name: ______________

Name of the Bank: ______________ Address of the Bank: ______________

______________ State: ______________ PIN Code: ______________

MICR: ☐☐☐☐☐☐☐☐☐ IFSC: ☐☐☐☐☐☐☐☐☐☐☐

Payout option: ☐Lump sum ☐ Regular Payment ☐ Annuity (Options are subject to applicable Terms & Conditions of the Policy.)

4. LIFE INSURED DETAILS

Name of the life insured: ______________ Date of Death: D D M M Y Y Y Y

Time of Death: H H M M AM/PM Place of Death: ☐ Home ☐ Hospital ☐ Office ☐Others (please Specify Others / Hospital name)

____

Cause of Death: ☐ Accident ☐ Murder ☐ Suicide ☐ Natural ☐ Illness ☐ Others (please specify)______________

5. NATURE OF ILLNESS & HABITS	Date of Diagnosis
☐Hypertension ☐ Diabetes ☐ Asthma ☐ IHD ☐ Malignancy ☐ Others (please specify)______________	
☐Smoking ☐ Alcohol ☐ Tobacco ☐ Drugs- if yes, duration of consumption______________ Quantity consumed______________ (Per-Day/Week/Month).	

6. EMPLOYER/BUSINESS/OCCUPATION DETAILS

*Last Employer's name/Business/Occupation:*____

Nature of work/designation:____

Employment/Business/Occupation Address: ____

State: _______________________ PIN Code:________________________ Mobile / Landline number:____________________________

7. NAME, ADDRESS AND CONTAT 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)

8. DETAILS OF *OTHER LIFE INSURANCE POLICIES* OF THE LIFE INSURED

Name of Life Insurance Company	Policy Number/s	Policy Commencement Date	Coverage Amount (Rs.)	Claim Submitted
				Yes/No
				Yes/No
				Yes/No

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 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 Photo Copy of this authorization shall be considered as effective and valid as the Original.

Signature*/ Thumb impression of **Claimant** ______________________________________ Date ____________________

Note: *Signature in vernacular languages must have their English translation written beneath. Further the claimant signing in the Vernacular language should give a declaration in the vernacular language that he/she has understood the contents of the above form fully and properly as explained to him/her in the language understood by him/her by an English knowing person who shall also sign to the effect that he/she has fully explained the contents of the above form to claimant.*

Place for Declaration in Vernacular Language:

Signature of **Witness**:		
Name of Witness:		**Date**
Address of Witness:		

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 submission of incomplete claim form and/or non-submission of the mandatory documents.

For Office Use Only

Branch to Affix **the date and time stamp** here with details of OSV/ASV with signature of Brach Service Associate.

HO, Claims to Affix the date seal here.
(Time, if received directly.)

Application No. ______________________________