GROUP LIFE ASSURANCE CLAIM FORM

Policyholder _____

Policy Number _____

Full Name of Life Assured _____

Claim for Insured Event: _____

Date of Incident _____

Date when Life Assured joined the Policy _____

Documents required to be attached to this Form (Please tick next to the document provided)

Death	Disability	Critical Illness	Funeral Expense
Notification Letter from Policyholder	Notification Letter from Policyholder	Notification Letter from Policyholder	Notification Letter from Policyholder
Death Certificate (original to be provided for sighting)	Medical Report certifying the Disability	Critical Illness Claim Form	Burial Permit
Police Abstract (for accident death only)	Police Abstract	Medical Report certifying the Illness	
Last monthly pay-slip	Last monthly pay-slip	Last monthly pay-slip	
Copy of National ID/Surrender of ID	Copy of National ID	Copy of National ID	

We hereby undertake that aforementioned information and attached statements are true and complete to the best of our knowledge and hence authorize you to settle the claim as per the Policy Terms & Conditions

DATED _____

NAME & SIGNATURE _____

POSITION OF SIGNATORY _____

FOR & ON BEHALF OF _____

(Rubber Stamp)