# STATE LIFE

**Insurance Corporation of Pakistan**

**Claim Form A**
**(Form –IVA)**

## CLAIMANT'S STATEMENT

Policy No: ____________________________Name of the Life ________________________________

Instructions for completion of this form:

- This form is to be completed by the person legally entitled to claim policy moneys i.e. Nominee, Guardian, Trustee, Assignee OR holder of Succession Certificate.
- In case if there are more than one claimants, each will be required to submit a separate form.
- Please provide complete information. Incomplete and blank forms and columns left blank will not be entertained.
- Please fill in the form with clear and legible handwriting and avoid cutting and overwriting.

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1. Please provide following information about yourself:

   Name: ____________________________________ CNIC No: ____________________________

   Age or date of Birth: ______________________ Occupation: _______________________________

   Address: _________________________________________________________________________

   ______________________________________________________________________________

   Cell/Phone No: ______________ Fax No: _______________ Email Address: ____________________

   Relationship with the life Insured: ______________________________________________________

2. Please tick the box below describing nature of your title under which you claim the policy money:

   ☐ Nominee ☐ Guardian ☐ Trustee ☐ Assignee ☐ Successor

3. Please provide details about the deceased life insured:

   Name: ___________________________________ CNIC No: ______________________________

   Last Occupation: _________________________________________________________________

   Last Address: ____________________________________________________________________

   Date of Death: ___________________ Place of Death: ___________________________________

   Immediate cause of death: ____________________________________ Age at death: __________

   Duration of last illness: _____________________________________________________________

4. Please state particulars of other life or health insurance policies of the life Insured:

   Policy No(s): _____________________________________________________________________

   Date(s) of issue: __________________________________________________________________

   Issuing Office(s): _________________________________________________________________

5. (a) Please state as to when did the deceased life insured first complain of being not in usual good health_______________ (b) Nature of illness then complained of: ___________________________

6. Please provide details of medical attendant(s) consulted during last illness of the deceased:

| | |
|---|---|
| a) Doctor's / Hospital/Name<br>b) Address<br>c) Dates of consultations<br>d) Complaints | a) Doctor's / Hospital/Name<br>b) Address<br>c) Dates of consultations<br>d) Complaints |

(Please attach the prescriptions/Hospital certificate/Lab reports/postmortem/FIR and /or any other document.

7. Please provide following details about the illness of life insured pertaining to the last three years:

| **Doctor's Name and Address** | **Date of First Consultation** | **Nature of Complain** |
|---|---|---|
| | | |
| | | |
| | | |

8. Please list out below the particulars of family members of the deceased has left:

| **Names** | **Ages** | **Relationship with the deceased** |
|---|---|---|
| | | |
| | | |
| | | |

9. Please state is there any will? If yes, then please attach a copy of the same.

**Declaration:** I _________________________________________________________ do hereby declare that the information provided by me in this form is true in each and every respect and that I have not withheld any material information.

I being __________________________________ of the deceased, hereby authorize any hospital, physician or any other person who had attended the life insured to give State Life all the knowledge and information which was thereby acquired including the history obtained and diagnosis made.

Signed at ______________________________ this _________________ day of ____________________ 20 ____

____________________
(Signature/LTI/RTI of Claimant)

**Attestation:**
The statement below must be signed by a Grade-17 and above, Nazim, Naib Nazim, Chief Executive Officer of Municipality Justice of Peace, Magistrate, collector or Judge of the place or district where the death took place or an officer of State Life (not below the rank of Area Manager on the administrative side if he or she knows the claimant.
I certify that the claimant has signed it before me and I have verified his or her CNIC

Signature with seal: ____________________________________________ Date: __________________________________
Name: _________________________________________________________________________________________________
Address: _______________________________________________________________________________________________

Phone No: ______________________ Fax No: _________________________ CNIC No: _____________________________