

**STATE LIFE**

INSURANCE CORPORATION OF PAKISTAN

(a) Doctor's (Hospital's) Name: _____
 Address: _____
 Date (s) of Consultation: _____ Complaints: _____

8. Please provide following details about the illnesses of the insured during the last three years and provide medical file, (if any):-

Doctor's Name & Address	Date of First Consultation	Nature of Complaint

9. Please list below the particulars of family members the deceased has left:-

Name	Age	Relationship with the Deceased

10. Please state is there any will, if yes, please attach the copy of the same

Declaration:

I, _____ do hereby declare that, the information provided by me in this claim 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.

I, hereby acknowledge that the sharing of bank account details, whether during the acquisition or provision of such information, shall not be construed as an acknowledgment of any liability or claim. This act is strictly intended for facilitation purposes and is contingent upon the admission of liability by the State Life. Any such admission, if made, will be subject to a thorough and diligent evaluation of the claim in accordance with the terms stipulated in the contract.

Signed at _____ this date _____ Day of _____ 20 _____

Signature of Claimant**Attestation**

The statement below must be signed by a Gazetted Officer, Municipal Officer, Justice of Peace, Magistrate, Collector or Judge of the place or district where the death took place or officer of State Life (not below the rank of Assistant Manager on the administrative side or Area Manager on marketing 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: _____ CNIC No: _____
 Address: _____
 Phone / Cell No. _____ Email: _____

