STATE LIFE
INSURANCE CORPORATION OF PAKISTAN

Claim Form A
CLAIMANT'S STATEMENT

Policy No. _____ Name of the Life insured _____

The issuance of claim form does not mean that claim under the policy has been accepted or that the corporation has waived-off the rights vested to it through the policy contract. State Life reserves the right to call for any other information, document and evidence, as it deems necessary

Instructions for completion of this form:

This form is to be completed by the person legally entitled to claim policy money i.e. nominee, guardian, Trustee, Assignee and holder of succession certificate.
In case there are more than one claimant, each will be required to submit a Separate form.
Please provide complete information. Incomplete and blank form will not be entertained.
Please fill the form with clear and legible handwriting and avoid cutting and overwriting.

1. Please provide following information about the claimant:

Name: _____ CNIC No: _____
Age or date of birth: _____ Occupation: _____
Relationship with the life insured: _____
Address: _____
Cell Phone No: _____ Email address: _____

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

Nominee ☐ Guardian ☐ Trustee ☐ Assignee ☐ Successor ☐

3. Bank Account No: _____ Bank: _____
Branch & Address: _____ Verification by the Banker (Seal & Signature): _____
IBAN # ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

4. Please provide details about 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 _____

5. Please state particulars of other life or health. Insurance Policies of the life insured:

Policy No.(s): _____
Date(s) of issue: _____
Issuing Office(s): _____

6. (a) Please state as to when did the deceased life insured first complained of being not in usual good health? _____

(b) Nature of illness then complained of _____

7. Please provide details of medical attendant consulted during last illness of the deceased:

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

(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: _____