PSRF164506121907 CANA	1				
INDIVIDUAL	For Official Use Only	Oranah Ca	ada.	Date: DDMMYY	HDFC
DEATH CLAIM	Branch Name: E	Branch Co	ode:	Time: On or Before 3PM	Life
	Employee Name:			After 3 PM	Sar utha ke jiyo!
FORM	Employee Code:	Sig	n:		3 1
support in this hour of nee	nces on your untimely loss. We understand d. This Death Claim form will help you file yo instructions below to help us settle your cla	ur claim v	with ease. Please su		
IMPORTANT INFORMA	TION				
2. Claims under multiple po 3. In case of more than one 4. Please read the declarat 5. The Claimant should sigr 6. Claim is payable subject 7. No fee or commission sh 8. Asterisk (*) refers to ma Pension claim- Section A,B	I by the claimant only. In case the claimant is blicies may be registered by filling a single for claimant, separate forms need to be filled frions carefully and sign the claim form in the n in all pages of this Claim form. to fulfillment of all terms and conditions of nould be paid to anyone to process this claim andatory information. I,E mandatory to fill; Death claim (Non-accid All sections are mandatory for filling.	rm & prov or each cl same ma the policy	viding all applicable laimant. anner as you normall y.	policy numbers.	
IMPORTANT GUIDELIN	ES TO FILL THE FORM				
	rm should be filled by theclaimant in B	LOCK let	tters.		
 Make sure your address, yethe correspondence will the Please fill the NEFT Form cheque/bank account passifications of the policy. Section B: Details of Life A Wherever you choose the given space. Provide supporting docur 	completely and enclose a copy of cancelled ssbook to enable us to transfer the claim procubject to the claim being payable as per the to	eeds erms and the	attending physic such document / • Concealment of or invalidation of the section D: Details • Provide detailed • Enclose/Attach F why it is not avail • Provide signature	of death due to Accident/Mu account of the accident. PMR and FIR, otherwise clearly lable or provided. Intion and Authorisation e and contact details in the des	is qualified to provide n Laws. Assured might lead to urder/Suicide state the reason
List of valid Identity &	Address Proofs (Please tick the doci	ıment s	submitted)		
-	to Identify Proof (any one)		,	Address proof (any one)	
PAN Card V	alid Passport Voter ID Card		Valid Passport		
Aadhar Card* V	alid Driving License		Voter ID Card		
Bank Passbook with st	tamped photograph (not more than 6 months	old)	Aadhar Card*		
ID Card Issued by Cent	ral/State Govt. to employees		Valid Driving Lice	nse	
Any other Central/Sta	te Govt. issued ID		Bank Passbook w	ith stamped photograph (not ı	more than 6 months old)
	onsent to use my Aadhaar to conduct identit	y check to	 owards KYC compliar	nce by HDFC Life	<u> </u>
DOCUMENTS TO BE SU	BMITTED				
	NDATORY DOCUMENTS			ADDITIONAL DOCUMENTS	
Original policy document (N	lot necessary in case of dematerialised policy document)	HOSPIT	ALISATION/ DEATH	I DUE TO ILLNESS	
Copy of death certificate is:		Copy of	Medical cause of de	ath Certificate	
Claimant's PAN details				e treatments taken in the p charge/ Death summary, Test	
Life Assureds' PAN details		ACCIDE	NTAL DEATH		

ACCIDENTAL DEATH

 $Disclaimer: HDFC\ Life\ Insurance\ Company\ reserves\ the\ right\ to\ ask\ for\ more\ information/\ documents, if\ required.$

Cancelled cheque , Cremation/Burial Slip , Employee certificate

in case Life Assured was Salaried

Claimant's passport size photograph



Copy of First Information Report (FIR), Panchnama /Inquest report, Post-mortem

report (PMR), Driving licence, Police Final Report, Viscera report, if applicable,

News paper cutting (s), if any, Others as applicable

SECTION A*																
POLICY DETAILS																
Policy Number(s):			,		,									Dlea	-0 of	=,
Claim form filling Assis	sted by:	HDFC Life E	Employee	Policy Ager	nt Relativ	es	NA								se afi cent	IX
If the option HDFC Life En	nployee or Rela	itives select	ed above, deta	ails										passi	orts o of t	
Relatives /Employee N	lame: M	۱r. Ms.													iman	
Contact: M O B																
DETAILS OF CLAIM	ANT															
Claimant Name:	Mr. Ms.	F	I R S	Т										L	A S	Т
Date of Birth:	D M M	ΥΥ	YY													
Address: F	I R S				L	А	S T				F	L	Α	Т	N	0.
BUIL	DIN					0	A D	N		E	/		0.			
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	/ V I															
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Dinasda	K I C	'	2 1	A I E												
Pincode:	0 5 5		-	D 5		E N		V		M		_			-	
Contact No.: Office &/or Personal E	mail ID:			RE				Y		IM						
				6.115			011									
Occupation details:	Service		siness	Self Employe				ners								
Monthly income (INR):			20,001-		50,001-1,00,0	100	>1,	,00,00)							
Relation with the Life		Spouse	Children		Others			5 1	E	C	I	F	Υ			
Claimant's Title:	Nominee	Exe	ecutor	Trustee	Appointee		Employ	/er	A	ssign	ee		Ben	eficiar	У	
					Tarm CO											
Claimant's PAN:				Or F	Form 60 Foi	m 61										
	cally Exposed	l Person (P	PEP)?	Yes	No "PEP: Persons	who are r	members o	of senior m	anageme	ent in a	state (owned	enterp	rise, Poli	tical pa	rty or an
Is the Claimant a Politi				Yes	No "PEP: Persons international o	who are r organisatio	on. i.e. dire	tors, depu	ty direct	ors and	state (membe	owned ers of tl	enterp ne boar	rise, Poli d or equi	tical pa valent f	rty or an unctions"
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Signature of Claimant

SECTION B*																												
DETAILS OF LIFE ASSU	RED	(LA))																									
Name of Life Assured:	Mr.		Ms.	F	-1	R	S	Т																L	Α	S	Т	
Father's Name: F I	R	S	Т																					L	А	S	Т	
LA's PAN																												
Date of death: D D	М	М	Υ	Υ	Ag	je at	dea	h:	Υ	Υ	М	М	Tin	ne of	dea	th:	Н	Н	:	М	М	:	S	S				
Place of death: Location	n:		Но	spit	al		wo	rk pla	ice		Hor	ne		0	ther	5			S		Е		ı	F	Υ			
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B U I L D	1		G											R	0	A	D	N	Α		Е		N	Ο.				
C I T Y /	V		L	L	Α	G																						
D I S T R	1		Т			S			Т	Е																		
Pincode:																												
If death outside India, body	y trans	sfer	perr	miss	ion/	Cert	ifica	tion f	rom	Cons	sulate	e :		Ava	ilable	е		Not	avai	lable	<u>.</u>							
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Whether burial or crematic	n cert	tifica	ite e	enclo	sed	/atta	ache	dacc	ordir	igly?	:		Ye	25		N	lo											
If Not Available,Why?																												
Place of burial/crematorium	n add	ress			F	1			Т					L	А	S	Т						L	Α	Т		N	
B U I L D	1	N	G		R	0			N	А	М	Е		N	0.													
C I T Y /	V		L	L	Α	G																						
D I S T R	1		Т			S			Т	Е																		
Pincode:																												
Nature of death:	edica	1		A	ccide	ent		М	urde	r		Sı	uicid	e														
Immediate cause of death:																												
Circumstances surrounding	g deat	:h:																										
Name and contact details of	of rela	tive	pres	sent	at ti	me o	of de	ath/o	rem	atior	ı/bur	ial:																
1st Name: F I R	S	Т																						L	Α	S	Т	
Contact details:			F		I	С											М	0	В									
2 nd Name: F I R	S	Т																						L	A	S	Т	
Contact details:		0	F	F	1	C	Е										М	0	В	-1	L	Е						
EMPLOYMENT DETAIL	S OF	LIFE	E AS	SSU	RED)																						
Occupation details:	Servi	ice		Вι	usine	ess		Se	lf-Er	nplo	yed		Ηοι	ıse v	vife		Oth	ers:		S	Р	Ε	С	-1	F	Υ		
Monthly income (INR)	Up	to 20	0,00	00		20	,001	-50,0	000		50	0,00	1-1,0	0,0	00		>1,	0,00	00									
Name of Employer:																												
Work place/employment/b	usine	ss ac	ddre	ess	F	1			Т					L	Α	S	Т						L	Α	Т		N	
B U I L D	1	N	G											R	0	Α	D	N	Α		Е		N	Ο.				
														L	А	N	D	М	Α		К							
C I T Y /	V		L	L	Α	G																						
D I S T R	1		Т			S			Т	E																		
Pincode:																												
Last working location/emp	oloym	ent/l	busi	ines	s:																							
Contact details of the Emp	loyer:								N	Α	М	Е									М		В		L	Е		
Last Working day: D	D	М	М	Υ	Υ	Υ																						

SIGN HERE

SECTION C																												
HOSPITALISATION DET	AIL	S OI	F LIF	FE A	SSU	IRE	D																					
Was the life assured diagnosed/suffering from/treated for the following illness?				Ну	perte	ensio	n		Diab	etes	╝	ľ	Hear	t dis	ease			Live	r dise	ase		Kid	ney	disea	ise			
trom/treated for the follow	ıng ı	iines	SS?			Car	ncer		╝		Oth	ers						S	Р	Е	С	1	F	Υ				
Date on which disease/illne	ess F	irst	diagr	nose	d	D	D	М	М	Υ	Υ	Υ	Υ															
Have any of your immediate	e fan	nily r	nem	bers	suff	erec	fror	n the	sim	ilar i	llnes	s?		Yes	╝		No I	f yes	, prov	ide c	letails	whe	n it v	vas ir	nitiall	y diag	jnose	d:
Details of treatment receive	ed in	iclud	ling d	lates	5 OT C	outpa	atier	it or i	npai	ient																		
Type of admission:	Eme	erge	ncy		Pl	ann	ed		Di	ay Ca	are		Ма	itern	ity		NA											
Treatment given, if no surg	ery:																											
Hospitalisation due to injur	y:		Yes			No																						
If yes, give cause:			Sel	lf-Inf	licte	d		R	oad [·]	Traff	ic Ac	cide	nt		Sı	ıbsta	nce /	Abus	e									
Status at the time of discha	irge:			D	isch	arge	d to	Hom	e		Di	ischa	irged	l to A	noth	ner H	ospit	al		De	cease	ed						
Medical cause of death cert	tifica	ite:		A۱	/ailal	ole		N	ot av	/aila	ble		Plea	ase er	nclos	e/att	ach. If	not	availa	ble,	state	the re	asor	۱.				
MEDICAL CONSULTATION For more than one doctor consu												_				-					t Dat	e)						
Name of Doctor:	1	R	S	Т																L	Α	S	Т					
Address of Hospital: F	1	R	S	Т										L	Α	S	Т					F		Α	Т	N	0.	
B U I L D	1	N	G											R	0	А	D	N	Α	М	Е	1	N	0.				
D I S T R	1	С	Т			S	Т	А	Т	Е											Pinc	ode:						
Contact Details of Doctor:																												
Dates of Consultation:	D	D	М	М	Υ	Υ	Υ	Υ																				
Reasons of Consultation:																												
DOCTOR DETAILS																												
Doctor who attended the	he la	ast i	illne	ess:				F			S												S					
Address of Hospital: F			S	Т										L	A	S	Т						L	A	Т			0.
B U I L D			G											R	0	Α	D	N	A	М	E	/	N	0.				
D I S T R			Т		_		T	Α	Т	E											Pinco	ode:						
Contact Details of Doctor:			0	F	F		С	E										М	0	В			E					
Family doctor: F			5	<u> </u>											Δ.	_	_						H		_		N	0
Address of Hospital: F			2												A	2	_	N.					<u> </u>	A			N	0.
B U I L D			G				_	Δ	_	E				R	0	A	D	N	A	М	Pinco	odo.	N	0.				
Contact Details of Doctor:			0	-	-		ı	F		-								M	0		PIIIC	oue.	_					
Doctor who declared de	22±				F		S_	E										М	0	В					Δ	S	T	
Address of Hospital:	zalí	I. R	S	7											A	S	T							Δ	T	- o	NI.	0.
B U I L D			G											P.	0	Δ	D	N	Δ	М			NL.	Λ Ω			-11	- J.
DISTR			T				T_	A	T	E				-17					-/\		Pinco	ode:		· ·				
Contact Details of Doctor:			0	F	F		С	E										М	0	В			Ę					
																								SIC	N H	-RE-		
																								114				

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LIFESTYLE DETAI Did the Life Assured	_	f drinking, smok	ing and/or cl	hewing tobacco?	Yes	No	If Yes, pleas	se provide deta	ils.	
Beer	Whiskey	Wine	Other	s: S P	E C	I F	Υ	ml/bottle per o	lay	
Cigarettes	Bidi	Tobacco	Gutka	Others:	S P		I F Y	No. of sticks or packets per da		
If the Life Assured ha	nd drug habits:	Name of drugs		N	lumber of	years		Dose usage		
Other substance add	ictions, if any:									
OTHER INSURANC	E/ MEDICLAIN	1 POLICY DET	AILS OF LIF	E ASSURED						
Policy	Name 0	f The	Basic	Risk		Claim	Status Ple	ase tick the appro	oriate boxes	
No.	Insura Comp		Sum Assured (SA)	Commen- cement Date (RCD)	Claim Applied	Claim Not Applied	Partial Claim Amount Received	Legal Appeal filed against the claim	Full Claim Amount Received	Claim Denied
				D D M M Y Y						
				D D M M Y Y						
				D D M M Y Y						
				D D M M Y Y						
				D D M M Y Y						
If claim not applied	l with other in:	surer, why?								
SECTION D										
In case of death o	due to Accide	ent/Murder/S	uicide							
Address & contact where FIR/Case Di										
If not registered, s	tate the reaso	on:								
Details of hospital was conducted										
Is the Post Morten	n report enclo	sed/attached?	Yes	No	f not attach	ned, kindly	state the reas	son		
Details of how the	incident hanr	pened?	Rail	Road Air	Others		SF			
			···				ocation of the	accident		
								SI	GN HERE	
Date: D D M	M Y Y Y	Y Place:						31	SATILINE	
butc.		i lace.						Claim	ant Cianaturo	
								Cidilli	ant Signature	

SECTION E*	
DECLARATION AND AUTHORISATION	
	to the best of mulimousledge Challet
 I hereby declare all the details filled/ furnished above are true and correct I hereby warrant the truth and correctness of the foregoing particulars in a statement, suppress or conceal any material fact, my right to claim reimbu I understand and agree that the submission of this form does not mean the lunderstand that any payout under the policy shall be strictly in accordance. 	every respect and I agree that if I have made or shall make any false or untrue rsement of the said expenses shall be absolutely forfeited. at the request will be processed.
 Any payment shall be subject to realization of the last renewal premium p. I authorise all the medical establishments (medical labs included), governincluding HIV/AIDS and others, related to the LA, to HDFC Life, from both to A photo copy of this declaration shall be considered as valid and effective. I authorise HDFC Life to share and obtain information on behalf of me with 	ment institutions (police, revenue, etc.) to reveal the treatment information the past and present.
authorities, other insurers, statutory authorities, employer, court, govern provider(s) for servicing insurance policy, underwriting risk, settlement of hereby provide my consent for the same.	
hereby provide my consent or the same.	SIGN HERE
Date: D D M M Y Y Y Place:	
CLAIMANT HAS AFFIXED HIS/HER THUMB IMPRESSION/HAS SI	GNED IN VERNACULAR / HAS NOT FILLED THE APPLICATION
I hereby declare that I have explained the contents of this application form to	
truthfully recorded the answers provided to me. I further declare that the Cla	imant has signed/affixed his/her thumb impression in my presence.
Third Party Name:	SIGN HERE
Address:	SIGNIENE
Contact Details:	
Date: D D M M Y Y Y Place:	Third Party Signature
NOTE	
With reference to recent regulatory changes, please submit PAN or Form 60 via My Account/service@hdfclife.com/18602679999/HDFC Life branch. Igno	if you do not have a PAN) with HDFC Life with immediate effect. Please update re if submitted.
HIDEOLOGIA CONTRACTOR AND	Line Hall Decision of College (1990) and the
HDFC Life Insurance Company Limited [Formerly HDFC Standard Life Insurance Compan Regd. Off: 13th Floor, Lodha Excelus, Apollo Mills Compound, N.M. Joshi Marg, Mahalaxmi, M	
	0
Customer Acknowledgement C	opy-Individual Death Claim Form
_	
Policy No. Branch Name / Interaction ID	Claimant Name Claimant Client ID
Employee Name	Date D D M M Y Y Y Y
Employee Sign	Employee Code
Zimployee Sign	Branch Stamp
List of valid Identity & Address Proofs (Please tick the docume	
Photo Identify Proof (any one)	Address proof (any one)
PAN Card Valid Passport Voter ID Card	Valid Passport
Aadhar Card* Valid Driving License	Voter ID Card
Bank Passbook with stamped photograph (not more than 6 months old)	Aadhar Card*
ID Card Issued by Central/State Govt. to employees	Valid Driving License
Any other Central/State Govt. issued ID	Bank Passbook with stamped photograph (not more than 6 months old)
*I voluntarily provide my consent to use my Aadhaar Card to conduct identity check tow	ards KYC compliance by HDFC Life.
HDFC Life Insurance Company Limited [Formerly HDFC Standard Life Insurance Compa Regd. Off: 13th Floor, Lodha Excelus, Apollo Mills Compound, N.M. Joshi Marg, Mahalaxmi, N. Call 1860-267-9999 (local charges apply). DO NOT prefix any country code e.g. +91 or 00. Avail (For NRI customers only) Visit – www.hdfclife.com.	Литваі - 400 011.