digit LIFE INSURANCE

RETAIL PRODUCT CLAIM FORM

The Claimant statement form must be filled and submitted in by **the claimant / beneficiary under the policy or by the legally entitled person**. Send all required documents to **lifeclaims@godigit.com**
If you are in doubt, you can get in touch with your **agent / Intermediary Broker / Digit representative** or call us on **9960126126 / 18002962626.**

GENERAL INFORMATION

DETAILS OF LIFE ASSURED (LA)

Policy No:

Name of Life Assured: ☐ **Mr.** ☐ **Ms.** **First Name**

Middle Name **Last Name**

Father's Name: First Name **Middle Name**

Last Name

Date of Death/Critical Illness: D D M M Y Y Y Y

Claim Request for:

- ☐ **Death Cover**
- ☐ **Accidental Death Cover Benefit**
- ☐ **Additional Accidental Death Benefit**
- ☐ **Accelerated Critical Illness**
- ☐ **Additional Critical Illness**
- ☐ **Accidental Total & Permanent Disablility**
- ☐ **Additional Accidental Total & Permanent Disablement**
- ☐ **Health Cover Benefit**
- ☐ **Accidental Cover Benefit**
- ☐ **Additional Personal Accident Benefit**

Place of Death: ☐ **Hospital** ☐ **Clinic** ☐ **Residence** ☐ **Office**

☐ **Other (Please specify)**

Family Doctor: First Name **Middle Name**

Last Name

Registration No.:

Contact No.: Country code + **Mobile Number**

Last Treated or Attended Doctor Name: First Name **Middle Name**

Last Name

Registration No.:

Contact No.: **Country code** + **Mobile Number**

Last Employer Details (if applicable):

Name of the Company/Firm:

Name of the contact person: **First Name** **Middle Name**

Last Name

Contact No.: **Country code** + **Mobile Number**

Nature of Death: ☐ **Medical** ☐ **Natural** ☐ **Accident** ☐ **Murder** ☐ **Suicide**

Cause of Death (if applicable):

NATURE OF ILLNESS AND HABIT OF THE INSURED

☐ **Hypertension** ☐ **Diabeteseteseties** ☐ **Heart Disease** ☐ **Liver Disease**

☐ **Kidney Disease** ☐ **Cancer** ☐ **Other (Please specify)**

☐ **Smoking** ☐ **Tobacco**

☐ **Drugs** **If yes, Duration of Consumption (in Years):** **& Quantity Consumed (Dosage per day):**

Date of Diagnosis of Illness: D D M M Y Y Y Y

OTHER INSURANCE DETAILS: (LIFE/MEDICLAIM/HEALTH)

Policy No:

Company Name:

Sum Assured:

Status: ☐ **Active** ☐ **Lapsed** ☐ **Applied** ☐ **Matured**

DETAILS OF CLAIMANT/NOMINEE/LEGAL HEIR

In case there is more than one nominee, please refer to and fill out the pages provided in the Annexure.

Claimant Name (In Case of Guardian, submit Guardian Certificate):

☐ **Mr.** ☐ **Ms.** **First Name**

Middle Name **Last Name**

Date of Birth: D D M M Y Y Y Y

Address:

City:

State:

Pin Code:

Landline No. (Residence): 0 -

Landline No. (Office): STD 0 - Phone

Mobile No. (Mandatory):

Personal Email ID:

Office Email ID:

Relation with the Life Assured: ☐ **Spouse** ☐ **Children** ☐ **Parents**

☐ **Other (Please specify)**

Claimant's Title: ☐ **Nominee** ☐ **Executor** ☐ **Trustee** ☐ **Appointee** ☐ **Employer** ☐ **Assignee** ☐ **Beneficiary**

Claimant's PAN/Form 60 Details: ☐ **PAN Card**

☐ **Form 60**

Politically Exposed Person: ☐ **Yes** ☐ **No**

Are you a US Citizen or US tax resident: ☐ **Yes** ☐ **No** **(If yes, please fill FATCA/CRS Certification)**

CLAIMANT NEFT MANDATE/BANK ACCOUNT DETAILS

In case of Children, if beneficiary is Major, please provide beneficiary's account details.

Bank Account Number:

Account Holder Name: **First Name** **Middle Name**

Last Name

Bank Name:

Branch:

Account Type: ☐ **Saving Account** ☐ **Current Account** ☐ **NRO Account** ☐ **NRE Account**

IFSC Code: **MICR Code:**

Mandatory for Pension Plans, Please indicate how you would like to receive the benefits.

☐ **Entire amount as Lumpsum** ☐ **Entire amount as Annuity** ☐ **Part as Annuity part as Lumpsum** ☐ **As Installments**

SECTION C*

DECLARATION AND AUTHORISATION:

- I hereby declare all the details filled/furnished above are true & correct to the best of my knowledge & belief.
- I hereby warrant the truth and correctness of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppress or conceal any material fact, my right to claim shall be absolutely forfeited.
- I understand and agree that the submission of this form does not mean that the request will be processed.
- I understand that any payout under the policy shall be strictly in accordance with the policy terms and conditions.
- Any payment shall be subject to realization of the last/due renewal premium payment.
- I authorise all the medical establishments (medical labs included), government institutions (police, revenue, etc.) to reveal the treatment information including HIV/AIDS and others, related to the LA, to Go Digit Life Insurance Ltd. from both the past and present.
- A photo copy of this declaration shall be considered as valid and effective.
- I authorise Go Digit Life Insurance Ltd. to communicate, share, access and obtain information about the Policy, Claim, life Assured on behalf of me with any reinsurer, insurance association, medical authorities, other insurers, statutory authorities, employer, court, governmental body, regulator, any other individual/entity using an investigation agency or other service or through their representative(s) and I hereby provide my consent for the same/Electronic Communication.

Date: D D M M Y Y Y Y **Place:**

Signature of Claimant:

DECLARATION TO BE MADE BY A THIRD PERSON

The Claimant has affixed his/her thumb impression/has signed in vernacular/has not filled the application. I hereby declare that the content of this application form has been explained to the Claimant in ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ language and have truthfully recorded the answers provided to me. I further declare that the Claimant has signed/affixed his/her thumb impression in my presence.

Name of the Declarant: **First Name** ☐☐☐☐☐☐☐☐☐☐☐☐ **Middle Name** ☐☐☐☐☐☐☐☐☐☐☐☐

Last Name ☐☐☐☐☐☐☐☐☐☐☐☐

Address:

City:

State:

Pin Code:

Date: D D M M Y Y Y Y **Place:**

Signature of Third Person:

Important Note: In case of any demand or favour asked by anyone including a company representative towards claim processing or settlement, the same should not be entertained and must be reported to the company immediately on the company's email id: **lifeclaims@godigit.com**

INSTRUCTION FOR FILLING UP THE FORM

A. IMPORTANT INFORMATION (Please read before filling the form)

1. The form should be filled by the Claimant only. In case the Claimant is a minor, the guardian/appointee may fill the form.
2. Claims under multiple policies may be registered by filling a single form & providing all applicable policy numbers.
3. In case of more than one Claimant, separate forms need to be filled for each Claimant.
4. Please read the declarations carefully and you should sign the claim form in the same manner as you normally sign your cheque.
5. Claim is payable subject to fulfillment of all terms and conditions of the policy.
6. No fee or commission should be paid to anyone to process this claim.
7. Make sure your address, phone numbers and email ID are current and active as the correspondence will happen through this only,
8. Asterisk (*****) refers to mandatory information.

B. DOCUMENTS TO BE SUBMITTED

MANDATORY DOCUMENTS

1. Original policy document (Not necessary in case of dematerialised policy document).
2. Death certificate issued by local authority.
3. Claimant's passport size photograph.
4. Personalized Cancelled Cheque or Bank Passbook (with Printed A/C no, IFSC & Name account holder).
5. Claimant's Valid Identity Proof.
6. Claimant's Valid Address Proof.
7. Claimant's PAN Card/Form 60 (if PAN Card not available).

ADDITIONAL DOCUMENTS

HOSPITALISATION/DEATH DUE TO ILLNESS

1. Medical cause of death certificate.
2. Medical records for all treatments taken in the past (Admission notes, History/Progress sheet, DIscharge/Death summary, Test reports, etc.).

ACCIDENTAL DEATH

1. First Information Report (FIR).
2. Panchnama/Inquest report.
3. Post-mortem report (PMR).
4. Driving license.
5. Police Final report.
6. Viscera report (if applicable).
7. Newspaper cutting(s), if any, Others as applicable.

Employer's certificate (Form) for Life Assured, if employed (not required for pension/annuity plans).

Disclaimers: 1. Copies to be submitted and originals to be presented at the time claim submission,
2. Go Digit Life Insurance Company Ltd. reserves the right to ask for more information/documents, if required.

CRITICAL ILLNESS:

1. Duly completed Claim Form signed by Claimant.
2. Medical Report(s)(current and past) including Investigation test(s), treatment report(s) and indoor case papers
3. Hospital Summary/Discharge Card
4. Medical Practitioner's Certificate confirming the current health status (Details of diagnosed Illness/Treatment advise)
5. KYC document of Claimant

C. LIST OF VALID IDENTITY & ADDRESS PROOFS (Please tick the document submitted)

PHOTO IDENTITY PROOF (ANY ONE)

☐ **Aadhar Card*** ☐ **Valid Passport** ☐ **Voter ID Card** ☐ **Valid Driving License**

ADDRESS PROOF (ANY ONE)

☐ **Valid Passport** ☐ **Voter ID Card** ☐ **Aadhar Card*** ☐ **Valid Driving License**

*I voluntarily provide my consent to use my Aadhar and other provided KYC documents to conduct identity check towards KYC complaince by Go Digit Life Insurance Company Ltd.

D. NOTE: CLAIMANT NEFT MANDATE/BANK ACCOUNT DETAILS

- A cancelled personalized cheque with the account no. and IFSC should be submitted along with the NEFT mandate. If the cheque is not personalized, a latest bank statement or copy of passbook (where account number and IFSC is mentioned) needs to be submitted with the mandate.
- This mandate, upon processing, will override any of the previously tagged NEFT mandates for all policies, held by the client with Go Digit Life Insurance Company Ltd.
- In case of NEFT failure or any further requirements pending on the mandate, payout will be kept on hold till fresh NEFT mandate is received. Intimation will be sent to you for the same.

Bank Confirmation letter as an evidence for premium(s) paid through NRE account.

#Refund to NRE account (full or proportionate) will be subject to ratio of premium(s) paid through NRE Account. Please submit a Bank Statement or

##In case of proportionate payout, please provide two NEFT mandates i.e. for NRE account and non-NRE account.

CUSTOMER ACKNOWLEDGEMENT COPY-INDIVIDUAL DEATH CLAIM FORM

Policy No:

Branch Name/Interaction ID:

Employee Name: **First Name** **Middle Name**

Last Name

Employee Sign:

Employee Code:

Claimant Name: **First Name** **Middle Name**

Last Name

Claimant Client ID:

Date of Birth: D D M M Y Y Y Y

Branch Stamp:

CONSENT FORM

To,

The Claims department,

Go Digit Life Insurance Company Limited,

Subject: Consent Form from Claimant/Nominee for conducting checks and obtaining documents for Death Claim

Policy Number(s): Policy 1

Policy 2

Policy 3

I, ☐ Mr. ☐ Ms. (Claimant name) First Name

Middle Name **Last Name**

(relation) of ☐ Mr. ☐ Ms. (name of the life assured) First Name

Middle Name **Last Name**

hereby give my consent to "Go Digit Life Insurance Company Ltd., and/or its representative to obtain records (including photocopies)/information pertaining to the Employment records, medical treatment records from any employment, business, Hospital/Clinic/Doctor, medical treatment/ Death related records or any other records pertaining to treatment/occupation/death, income, financials, of the Life Assured and such other information as may be required by Go Digit Life Insurance Limited.

Yours faithfully,

Name of the Claimant: First Name **Middle Name**

Last Name

Signature: