STATE LIFE
INSURANCE CORPORATION OF PAKISTAN
Registered & Supervised by the Securities

Dated : _____

Ref : _____

Dear Sir / Madam:

Sub: Policy No. _____ , Late _____

We are sorry to learn about the death of the life insured under above policy. We pray to the Almighty that his or her soul may rest in peace.

For assessment and evaluation of death claim, we need certain information. For this purpose, we are enclosing a set of following claim forms for completion as per the instructions given in each:

- ☐ Claim From A-Claimant's Statement to be completed by the person legally entitled to claim policy moneys.
- ☐ Claim Form B:Madical Attendant's Certificate to be completed by the medical attendant who had treated the life insured in his or her last illness.
- ☐ Claim Form C-Certificate of Identity to be completed by a person who knew the deceased life insured but is not related to him or her and has no intent in the policy moneys.
- ☐ Claim Form D-Certificate of employer to be completed by the employer of the deceased life insured

Please return us the above forms duly completed and attested alongwith following documents:

1. Original policy document
2. Death certificate issued by the concerned union council;
3. Attested photocopy of national identity cards of the life insured and the claimant;
4. If age of the life insured is not admitted, please send us an attested copy of his or her age proof such as educational certificate, birth certificate or employment record.
5. If nominee under the policy was minor at the time of appointment and is now major, please provide us attested copy of his or her age proof.
6. Receipt of the last paid premium.

In case the life insured has expired as a result of an accident or was murdered, please provide following additional documents:

7. Police reports-FIR and investigation
8. Postmortem report.
9. Clipping of the newspaper where news of accident or murder was published.

If the life insured has expired outside Pakistan then the claim forms, relevant reports and documents, executed abroad and issued by the foreign authorities, must be attested by the concerned Embassy of Pakistan in that particular country. If burial has taken place in Pakistan, the document s related to the carriage of death body to Pakistan and burial here must be provided.

This is for your kind information that issuance of claim forms does not mean that your claim under the policy has been accepted or that the Corporation has been acquitted of the rights vested to it through the policy contract. State Life reserves the right to call for any other information, documents and evidences , as it deems necessary. If you face any difficulty in completion of claim forms or other requirements, you may please contact us on the address given above. We will glad to assist you in this connection.

Your truly,

Manager (Claims)

Enc. As mentioned above

Claim-15

STATE LIFE

INSURANCE CORPORATION OF PAKISTAN
KARACHI CENTRAL ZONE

PLOT NO. D-15, AL-FARHAN TOWER
BLOCK 'H', NORTH NAZIMABAD, KARACHI
PHONE NO: 021-99260025 & 021-99260019
FAX NO. 021-9260010

CLAIM FORM A
CLAIMANT'S STATEMENT

POLICY NO: _____ NAME OF THE INSURED: _____

Instruction for completion of this form:

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

1. Please provide following information about the life nominee:
   Name: _____ CNIC: _____
   Age or date of birth: _____ Occupation: _____
   Address: _____
   Mobile No: _____ Fax: _____ E-mail: _____
   Relationship with the life insured: _____
2. Please tic box below describing nature of our title under which you claim the policy money:
   ☐ Nominee ☐ Guardian ☐ Trustee ☐ Assignee ☐ Successor
3. Please provide details about deceased life insured.
   Name: _____ CNIC: _____
   Last Occupation: _____ Occupation: _____
   Last Address: _____
   Date of Death: _____ Place of Death: _____
   Immediate date 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 Officer: _____
5. (a) Please state as to when did the deceased life insured first complain of being not in usual goof health? _____
   (b) Nature of illness then complained of: _____
6. Please provide details of medical attendants consulted during last illness of the deceased:
   (a) Doctor's (Hospital's) Name: _____
   Address: _____
   Date (s) of consultation: _____ Complaints: _____
   (b) Doctor's (Hospital's) Name: _____
   Address: _____
   Date(s) of consultation: _____ Complaints: _____

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

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

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

Name	Ages	Relationship with the Deceased

9. Please state is there any will? Incase if yes; attach a copy of the same:

Declaration:

I _____ do hereby declare that the information provided by me in this claim is true in each and every respect and that I have not with held any material information.

I being _____ of the deceased hereby authorized 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 included the history obtained and diagnosis made.

Signed at _____ this _____ day of _____ 20____.

(Signature of the Claimant)

ATTESTATION

The statement below must be signed by a Gazetted Officer, CEO of Muncipality, Justice of Pease, 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 Administration 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: _____

Address: _____

Phone No: _____ Fax No: _____ CNIC No: _____

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CLAIM FORM B
MEDICAL ATTENDANT'S CERTIFICATE

POLICY NO: _____ NAME OF THE INSURED: _____

Instruction for completion of this form:

- This form is to be completed by the medical Attendant who had treated the life insured in his or her last illness.
- In case of there are more than one medical Attendant claimant, each will be required to submit a separate form.
- Please provide complete information. Incomplete and blank forms will not be entertained.
- Fill in the form with clear and legible hand writing and avoid cutting and overwriting.

1. Please provide following information about the life insured:
   Name. _____ Father's Name: _____
   CNIC No: _____ Date of birth or apparent age: _____
   Mark of identification: _____ Occupation: _____
   Address: _____
   Habits: _____
   Relationship with the life insured: _____
   Was the life insured relates to you? If so how? _____
2. Please provide the following details about death of the life insured:
   Date of Death: _____ Time of Death: _____
   Place of Death: _____
3. Please provide following details about cause of death:
   a) Primary cause of death: _____
   b) Secondary cause of death: _____
   c) Results of autopsy or postmortem (if conducted): _____
   d) Above cause of death ascertained by: _____
      ☐ Examination after death
      ☐ Symptoms and appearance during life
   e) Preceding disease and illness: _____
   f) Co existing disease and illness: _____
4. Please answer following questions about presenting illness and treatment.

What were the symptoms of illness?
When did the deceased first observe them?
What was the date on which you were first consulted during the illness?
Did you attend him or her during the whole of its course? If not state during what period?
Did any other doctor/hospital attend him or her in last illness before or in consultation with you? Please specify names and address:
How long had he or she been suffering from this disease before his or her death?

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Do you have any reason to suppose or to suspect that disease caused or aggravated by intemperate habits.
Whether the deceased was aware of the nature of his disease?

5. Please answer the following questions related to the past history of the life insured:

What disease or conditions the life insured has?
What were the dates of diagnosis of above disease or conditions?
Who has treated the life insured for these diseases and conditions? Please specify name and address of the treating doctors/hospitals:
Who has reported this history to you?

6. Are you his her usual medical attendant? Please appropriate box.

☐ Yes, Since _____ No, _____

7. Please specify what disease or illness you have treated the life insured during last three years _____

8. If you have replied in negative to question 6 above, please specify the name and address of the usual medical attendant(s) of the life insured _____

9. Please specify any other information which you feel pertinent _____

10. Please describe any other information of remarks to make in connection with this claim concerning the deceased's aliments, habits and mode of living etc? _____

I _____ medical attendant of the deceased _____ Do here by solemnly declare that the foregoing statements are true and correct to the best of my knowledge and belief that the deceased does not die by his own act.

Signed at _____ this _____ day of _____ 20 _____.

Signature with seal _____ Date: _____
Name: _____ Qualification: _____
Address: _____ Phone No: _____

Witness to signature and identity of medical attendant:
Signature with seal: _____ Date: _____
Name: _____ Occupation: _____
Postal Address: _____

Note: if the medical attendant is civil or assistant surgeon or the one of the State Life's authorized medical examiner, his or her signatures of this form may be witnessed by the person of character and responsibility other than a relative of the deceased life insured. In other cases, the witness must be Gazetted Officer, Justice of Peace, Magistrate Collector or Judge of the place or District where the death took place or officer of the State Life (not below the rank of Assistant Manager on the administration side or Area Manager on Marketing side), if he or she knows the claimant.

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CLAIM FORM C
CERTIFICATE OF IDENTITY

POLICY NO: _____ NAME OF THE INSURED: _____

Instruction for completion of this form:

- This form is to be completed by the person who personally knows the life insured /deceased and have taken part in the burial / committal / funeral of the deceased
- Please attach the attested copy of C.N.I.C of the identifier.
- Please provide complete information. Incomplete and blank for will not be entertained.
- Please fill in the form with clear and legible handwriting and avoid cutting and overwriting.

I, _____

Do hereby declare that I know. Mr. /Mst. _____

S/o. W/o. D/o _____

Residing at _____

Prior to his death for the last _____ years and _____ months and that he / she died aged about _____

years at _____ on the _____ days of _____ 20____

after suffering _____ for _____ years and _____ months.

His / her personal appearance was as follows: _____

_____

_____

_____

I am satisfied that he/she is the same person who was described in the policy issued by the State Life Insurance Corporation of Pakistan in the year _____ and on whose death the above named claimant is now making claim on the State Life.

Signature _____

Signed at _____ this _____ day of _____ 20_____.

ATTESTATION

The statement below must be signed by a Gazetted Officer, CEO of Municipality, Justice of Pease, 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 Administration side or Area Manager on Marketing side), if he or she knows the claimant.

I certify that the identifier of the deceased 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: _____

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CLAIM FORM D
CERTIFICATE OF EMPLOYEE

POLICY NO: _____ NAME OF THE INSURED: _____

Instruction for completion of this form:

- This form is to be completed by the authorized person of employer/company/corporation where the insured/deceased was employed.
- Please provide complete information. Incomplete and blank for will not be entertained.
- Please fill in the form with clear and legible handwriting and avoid cutting and overwriting.

I/We _____ do hereby declare that Mr./Mrs./Ms _____ S/o. D/o. W/o. _____ was employed with us for _____ year's _____ months at _____. His/her last attended business (this office) on _____ for _____ year's _____ month's _____ days. His/her personal appearance was as follows: _____

His/her date of birth as per service record is _____. A copy of his age proof submitted with us is enclosed.

As per our record, the above named person availed of the following leaves years prior to his/her death

From: _____ To: _____

Period		Reason for leaves mentioned in the application
From:	*To:*	
From:	*To:*	
From:	*To:*	

Copies of the leave application and medical certificates provided in support are attached.

I am/we are fully satisfied that he /she is the same person described in the policy issued by the State Life Insurance Corporation of Pakistan as the insured.

Signed at _____ this _____ day of _____ 20___.

Official seal of the company

(Signature of Authorized Officer)

Name: _____
Designation: _____
Address: _____
Phone No: _____
Fax No: _____

ATTESTATION

The statement below must be signed by a Gazetted Officer, CEO of Muncipality, Justice of Pease, 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 Administration side or Area Manager on Marketing side), if he or she knows the claimant.

I certify that the information provided in this form is completed to the best of my knowledge and belief.

Signature with seal: _____ Date: _____
Name: _____
Address: _____
Phone No: _____ Fax No: _____ CNIC No: _____