Annexure I
FORM NO. 3783
CLAIM FORM 'A'

LIFE INSURANCE CORPORATION OF INDIA

Divisional Office ……..

Branch Office ……..

CLAIMANT'S STATEMENT

(To be filled in by the person legally entitled to the policy moneys)

(All answers to be filled in legibly. Answers must be given in words, strokes of the pen or dots or dashes cannot be accepted as replies)

In connection with claim under Policy No ……. For Rs……. on the life of …… I, as the claimant under the

(insert full name of the deceased)
policy make the following statement:

1. Particulars regarding the claimant :

(i)	Name of the Claimant	……..
(ii)	Age	……..
(iii)	Telephone No.	……..
(iv)	Address	……..
(v)	Relationship to the decreased life assured	……..
(vi)	Nature of Title under which the claim for policy money is submitted viz: Nominee, Assignee, Executor, Administrator, Trustee or Benefciary……	

2. Particulars regarding the deceased life assured, Shri ……

(i)	Place of death of the life assured	…….
(ii)	Date of death:Exact time of death …..A.M./P.M	…….
(iii)	Age of the life assured at death	……..
(iv)	Duration of last illness	……..
(v)	Immediate cause of the life assured	…….
(vi)	Last occupation of the life assured	…….
(vii)	Last address of the life assured	…….
(viii)	Full name of deceased'd father	…….

3. Particulars regarding other policies on the life of the deceased :

Policy No.	sum Assured	Name of issuing Office	Date of Commencement	Whether with Double Accident or Extended Disability Benefits

4. (a) When did the deceased first complain of being not in usual good health?

(b) Nature of illness then complained

5. The names of the medical attendants during the last illness

6. Names and addresses of the doctors consulted during the last three years stating against each name the complaint for which he was consulted and the date or dates thereof;

	Date or Dates or consultation	Name of the Doctor or Hospital and address	Nature of complaint
1.			
2.			
3.			

I, ……do hereby declare that the statement made hereinabove is true in each and every respect.

Notwithstanding the provisions of any law, usage, custom or convention for the time being in force prohibiting anu Physician or Hospital from divulging any knowledge or information acquired by him/them in attending upon or examining a person on the ground of secrecy, I hereby authorise the Physician or Hospital who has attended upon or examined or treated the aforsaid deceased life assured life assured for any aliment or illness to divulge any knowledge or information regarding the deceased's state of healthe which he/they may have acquired whether before or after the policy was issued by the Corporation, to the Corporation, its offices and legal advisers or in any Court of Law.

Signature/Thumb impression of the claimant……
……..
Designation……
Address……
Declared at……this……day of……

……19……..before me.

……..
Signature of Witness

IF THE DECLARANT SIGNS IN VERNACULAR OR AFFIXES THUMB IMORESSION, THE WITNESS SHOULD ALSO SIGN THE FOLLOWING DECLARATION

CERTIFIED THAT THE CONTENTS OF THIS FORM WERE EXPLAINED TO THE DECLARANT IN VERNACULAR AND HE/SHE HAS AFFIXED HIS/HER SIGNATURE/THUMB IMPRESSION HERETO AFTER FULLY UNDERSTANDING THE SAME.

Countersigned by

Signature ……..

Designation……

Address ……

……

(This statement must be countersigned by (1) an Advocate, (2) an Agent if the Ciroiratuib (who is a member of an Agents' club at the level of Divisional Manager's Club or above), (3) a Bank Manager, (4) a Block Development Officer, (5) a Commissioner of Oaths, (6) a Doctor, (7) a Gazetted Officer, (8) a Head Master of a High School, (9) a Head Post Master or Departmental Sub-Post Master (but not a Branch Post Master), (10) a Magistrate, (11) An Officer or Development Officer of atleast 3 years standing or confirmed Development Officer recruited from the Agents, who were DM or BM Club Members before joining or Development Officer recruited from agents who were ZM or Chairman's Club members before joining or (12) President of a Village Panchayat or Local Body.