

Group Term / Employee Deposit Linked Insurance - Claim Intimation Form



*Mandatory details to be filled

Policy Number*:

Date:

Type of Policy*: ☐ Group Term ☐ Employee Deposit Linked Insurance

Type of Claim*: ☐ Death ☐ Critical Illness ☐ Disability
☐ Accidental Death Benefit Rider ☐ Accidental Total & Permanent Disability Benefit Rider ☐ Terminal Illness

Name of the Member*	
Member ID*	
Date of Birth	
Date & time of death/* Date of diagnosis of CI / Date of Disability	
Place of death (E.g. Address of hospital)	
Cause of Death/Claim* (Please specify exact cause of death or exact medical condition of CI or exact reason for disability)	
Last working date (If applicable)	
Sum Assured*	
Rider Sum Assured (If applicable)	
Annual CTC/ Monthly Income (If Sum Assured is above 10 lakhs)	

Details of leave taken one year prior to commencement of member's cover: (If applicable)

From (Date)	To (Date)	Reasons for Leave	Nature of Illness (in case of leave on medical grounds)

If leave has been taken on medical grounds copies of leave applications and medical certificates produced by the Member must be attached herewith.

Cause of Claim	Document Required
Non Accidental Death / Accidental Claim	⇒ Copy of Death certificate issued by local authority ⇒ Nominee Cancelled Cheque copy
Claim to be settled to*	⇒ Master Policy Holder <input type="checkbox"/> ⇒ Nominee / Beneficiary <input type="checkbox"/>

*Please provide the following details in case the claim payout cheque has to be issued in favour of the beneficiary:

Sr. No.	Nominee/Appointee Name	Nominee Date of Birth	Relationship	Nominee Contact Details	Share % of Claim Amount

PAYMENT DETAILS:

Term Amount to be paid (In ₹) :	Specify Name of Payee :
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We are aware that ICICI Prudential has a right to call for further information/documents.

ADVANCE DISCHARGE VOUCHER

We _____ (name of the Company) understand and agree that ICICI Prudential Life Insurance Company shall be discharged of all liabilities in relation to the above claim upon the payment of the Claim moneys in case of acceptance of the claim by the Company.

Please affix
Re. 1/- revenue
stamp & sign Stamp
of the Company:
across the
stamp

Stamp of the Company:

Signature of the authorized signatory: _____

Name of the signatory: _____

Place: _____ Date:

D

D

M

M

Y

Y

Y

Y

-: Instructions :-

1. Submission Methods: You can submit the form by any of these convenient methods:

▶ By email - Kindly submit the form to grouplife@iciciprulife.com from the official email id of the authorized signatory

▶ By Courier - Please courier the form to
Group Service Desk
ICICI Prudential Life Insurance Co. Ltd.,
Rani Sati Marg, Malad (E), Mumbai - 400 097.

2. The claim cheque would be dispatched to the last address recorded by us

3. For any assistance please write to us at grouplife@iciciprulife.com

4. ICICI Prudential Life Insurance Company shall be discharged of all liabilities in relation to the above claim upon receipt of claim amount by the payee mentioned above.

5. Insurance is the subject matter of the solicitation.