FORM NO. 3783(A)

LIFE INSURANCE CORPORATION OF INDIA

Divisional Office ……………………….. | Branch Office …………………………

CLAIMANT'S STATEMENT

(To be filled in by 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 replace)

In connection with claim under Policy No. …………………for Rs.…………………………
On the life of …………………………………………………………………………………………….

(Insert full name of the deceased)
I as the claimant under the policy make the following statement:

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1. Particulars regarding the claimant:
   - i) Name of the claimant…….
   - ii) Age …..
   - iii) Tel. No. ……………
   - iv) Address: ………………………………………………………………………………
     ……………………………………………………………………………..
   - v) Relationship to the deceased Life Assured: ………………………………………….
   - vi) Nature of Title under which the claim for policy Money is submitted, viz. Nominee, Assignee, Executor, Administrator, Trustee or Beneficiary ………………………………………………….

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2. Particulars regarding the deceased Life Assured

   Shri/Smt. …………………..

   - 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 death : …………………………………………………………..
   - vi) Last Occupation of the Life Assured : ……………………………………………….
   - vii) Last address of the Life Assured : ……………………………………………………
   - viii) Full name of deceased's father : ……………………………………………………..

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

Pol. No.	sum Assured	Name of issuing Office	Date of commencement	whether with Double Accident or Extended Disability Benefits.
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I, ……………………………………………… do hereby declare that the estatement made hereinabove is true in each and every respect.

Notwithstanding the provisions of any law, usage, custom or conuention for the time being in force prohibiting any 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 aforesaid deceased life assured for any ailment or illness to divulge any knowledge or information regarding the deceased's state of health 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.

Declared at …………………….this………………day of…………………….19 Before me.

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Signature of witness

Signature/thumb impression of the Claimant
Full Name :…………………………………..
Designation : …………………………………
Address : …………………………………….
Tel. No. ……………………………………...

Note : * (This statement must be countersigned by (1) an Advocate (2) an Agent of the Corporation (who is a member of an Agent's club at the level of divisional Managers' club or above), (3) a Bank Manager, (4) a Block Development officer, (5) a Commissioner of Oaths, (6) a Doctor, (7) a Gazetted Officer, (B) 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.

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

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

Signature : ……………………………….

Full Name : ………………………………

Designation : …………………………….

Address : ………………………………..

Tel. No. ………………………………….