PENSION & GROUP SCHEMES DEPARTMENT

Kolkata Metropolitan Divisional Office -- I

CLAIM FORM

For

Claiming benefit payable under the Group Savings Linked Insurance Scheme
(To be completed by the Grantees)

1) **Name of the Institution** :

2) **Master Policy Number** :

3) **Name, membership number & identification number of the insured Member** :

4) **Date of Birth** :

5) **Date of Joining the Scheme** :

6) **Due date for payment of the first contribution (Indicate day, month & Year)** :

7) **Mode of exit (Death, Retirement, Resignation, Termination of service etc.)** :

8) **Date of exit from Scheme** :

9) **Due date for payment of the last contribution (indicate day, month & year)** :

10) **The date on which the last contribution was paid to the Corporation.** :

11) **Whether any premium remains unpaid during membership, if so, give details** :

12)

Monthly contribution at the time of entry	Monthly contribution at the time of exit

13) **If there has been a change in the monthly contribution during his membership, indicate.**

Dates of Change	Revised Rate of Contribution

14) **Cause of death (in case of exit by death) in case of death, please send with this form an Original death certificate issued by the Registrar of Deaths.**

15) **Name of the Beneficiary and relationship to the member (in case of death)**

16) **Nature of proof of death (Please enclose Original Death Certificate & Xerox of it in case of death, please send with this form an original Death Certificate issued by the Register of Death. Original death certificate will be verified after verification with the Xerox.**

We declare that the above particulars are true & correct and the above member was an Insured Member covered under the Scheme on the date of his exit that all premiums have been paid to the Corporation on his behalf.

We confirm that the beneficiay mentioned above is the person appointed by the member to receive the benefit under the scheme.

Dated at ..... this .....

day of ..... 200 .....

Witness :

Signature :

Name :

Address :

.....

Signature of the Master Policy Holder

(Office Seal)

DISCHARGE VOUCHER POLICY NO. .....

We, the Master Policy Holder of .....

.....

do hereby acknowledge receipt from the LIFE INSURANCE CORPORATION OF INDIA, the sum of Rupees ..... in full satisfaction and discharge of all claims and demands of surrender Value/Death Claim/ Maturity Claims due in respect of/Assurance effected under the above Master Policy favour of ..... members under Serial No.s Maturity Claim/ Death Claim/Surrender Value Rs ..... only

Dated at ..... This

..... Day of ..... 200.....

.....

Revenue Stamp

.....

Signature of the Witness

Name :

Designation :

Address :

.....

Signature of the Master Policy Holder

with Office Seal