Punjab Life
Insurance Company Limited

PUNJAB LIFE INSURANCE COMPANY LIMITED (PLIC)
GROUP LIFE - DEATH CLAIM FORM

NOTE: Please don't leave any blank, unanswered question, date and/or signature, wherever applicable.

1. Employer / Policyholder Information:			
Name of Company / Employer		Group Policy No.	
Name of Contact Person		Contact Number	
Address			

2. Covered Member's Information (Deceased):			
Deceased's Name		Father's / Husband's Name	
CNIC No.		Age	
Date of Birth of Deceased	____ / ____ / _____	Marital Status	

3. Occupational Information:			
Employee No.		Date of Joining of Company	____ / ____ / _____
Designation		Occupation (at Date of Death)	
Monthly Salary (PKR)		Work Address	

4. Event Information:			
Date of Diagnosis	____ / ____ / _____	Date of Death	____ / ____ / _____
Place of Death		Primary Cause of Death	
Secondary Cause		Last Attended Usual Work	____ / ____ / _____
First Complaint / Indication of Last Illness			

5. Claim Information:			
Amount of Claim (PKR)		Title of Cheque	
Mode of Payment	☐ Cheque ☐ IBFT	Account No. (IBFT)	
Bank Name		Branch Name	

Punjab Life
Insurance Company Limited

6. Declaration by Employer / Authorized Representative:
The undersigned hereby asserts a claim to the afore-mentioned coverage, explicitly acknowledging that the written statements provided by the attending physicians shall serve as integral components of the proof of death, by agreeing that the submission of this form does not constitute a waiver of any rights or defenses. Further, confirms that the deceased was fully fit/healthy, not suffering from any disease or illness at the time of joining the organization or at the time of enrollment in the scheme. Additionally, I/We hereby authorize any physicians, hospitals, clinics, medical service providers, insurance companies, or any other relevant institutions or individuals holding records or information pertaining to the aforementioned life to furnish Punjab Life Insurance Company Limited (PLIC) with complete information, including copies of records related to any sickness, accident, disability treatment, examination, medical investigation, advice, or hospitalization. A photocopy of this authorization is deemed as valid as the original.

Employer Signature: _____ Name: _____	**Company Stamp:**
Date: ____ / ____ / _____	

CHECKLIST OF DOCUMENTS: (Please ✓enclosed documents)			
☐	Physician's Statement	☐	CNIC of Deceased
☐	Death Certificate (NADRA)	☐	Death Certificate (Hospital)
☐	Complete Past Treatment Record (if any)	☐	Attendance Record (Last 6 Months)
☐	Salary Record (Last 6 Months)	☐	Copy of Autopsy Report (if any)
☐	Copy of Driving License (For Accident only)	☐	Copy of FIR / Police Report (if unnatural cause)