



**PAYOR RIDER CLAIM FORM**  
**CLAIMS DOCUMENT CHECKLIST (CDCL)**

**Life Assured Name:**

**Policy No.:**

- Please submit this form along with the requirements mentioned below at the nearest branch or address mentioned overleaf for faster processing of claim.
- Please note that all documents needs to be self attested.

Payor Rider Claim Requirements	Yes/ No
1. Original Death Certificate or attested copy thereof issued by Municipal Authorities.	
2. Claim Form duly filled, signed by claimant and duly attested by an authorized person as mentioned in claim form	
3. Original Policy Document (s).	
4. Authorization Form duly filled, signed by claimant	
5. Copy of Claimant's current address proof	
6. Copy of Claimant's Photo Id proof which establishes relationship with life assured	
7. Last Medical Attendant Report	
8. Copies of Medical Records, Test Reports, Discharge/ Death summary, indoor case papers, Outpatient Consultation Notes	
9. Employer's questionnaire	
<b>In case of accidental/ unnatural death, in addition to the above , the following documents are required</b>	
10..Copy of First Information Report ( FIR)	
11.Copy of Post Mortem Report, Viscera Report	
12. Inquest Panchanama	
13. Policy Final Investigation Report	
14. Newspaper cutting	





9. Title under which the claim is submitted (Please Tick)

1. Nominee  2. Appointee  3. Survivor  4. Assignee  5. Trustee   
6. Beneficiary  7. HUF

10. If there is any other claim underlying the policy, please tick the appropriate box and submit respective claim form for the same.

HCB  Critical Illness  Permanent Total Disability

**Section II Details of Deceased Owner**

Date of Birth

Date of Death  Time of Death  a.m./p.m.

Place of Death \_\_\_\_\_

Cause of Death \_\_\_\_\_

If Place of Death is outside India: Yes  No

Was the deceased buried or cremated abroad? If yes, enclose a copy of the burial/ cremation permit.

**Employment Details:** Name of the Employer's /Business Name

Address :

City & Pin Code : \_\_\_\_\_ Mobile or Phone no. \_\_\_\_\_

Exact nature of Job/ Business \_\_\_\_\_

**Death due to Accident:** Date of Accident  Time of Accident \_\_\_\_\_ a.m./ p.m.

Place of Accident \_\_\_\_\_

Please provide duly attested copy of documents mentioned in the checklist for accidental death (From 8 to 12)(Mandatory)

**Death due to Illness: Date of First Complaint of Symptoms**



Name of the Doctor/Hospital who was consulted for illness's during the last three years.

Name of the Doctor/ Hospital or Clinic	Address, Contact No	Date of Consultation	Nature of Illness

**Section III: Details of Other Life Insurance Policies on the life of the deceased**

Policy No.	Sum Assured	Name of Insurance Company	Date of Commencement	Claim Status	Rider Coverage (If any)

Declaration:

In connection with claim under policy no.           for Rs. \_\_\_\_\_  
 on the life of \_\_\_\_\_ Owner, I \_\_\_\_\_ Claimant, do hereby  
 declare that the statement made herein above is true in each and every respect.

\*Countersigned By: \_\_\_\_\_  
 Date \_\_\_\_\_  
 Designation \_\_\_\_\_  
 Address \_\_\_\_\_

Signature of the Claimant: \_\_\_\_\_  
 Address: \_\_\_\_\_

Certified that the contents of this form were explained to the declarant in vernacular and he/she has affixed is/ her signature/ thumb impression hereto after fully understanding the same.

Signature \_\_\_\_\_  
 Name of the Witness: \_\_\_\_\_  
 Designation: \_\_\_\_\_  
 Address: \_\_\_\_\_

\* This statement must be countersigned by: (1) an Advocate (2) A Bank Manager (3) A Medical Practitioner (4) A Gazette Officer (5) A Head Master/ Principal of a local Govt. High School (6) A magistrate (7) President Of A Village Panchayat or Local Board (8) Sales Manager



**AUTHORISATION**  
*(To be filled & signed by the Claimant)*

Life Insurance Policy No.(s) \_\_\_\_\_

I, Mr. / Mrs / Ms. \_\_\_\_\_ *(name of the claimant),*

\_\_\_\_\_ *(relation with Life Assured)* hereby give my consent to M/s Aviva Life Insurance Company India Limited, and / or its representative to obtain all employment / medical / hospital records / police records / other records (including photocopies) / information pertaining to the treatment / occupation of the deceased Life Assured which he/ they may have acquired whether before or after the policy as well as details from other Life Insurance Companies regarding any existing policies which he / they may have sourced before or after the initiation of this contract.

Date:

Yours faithfully

Place:

(Signature of Claimant)

Contact details of the claimant:

Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pin: \_\_\_\_\_

Landline: STD Code \_\_\_\_\_ No. \_\_\_\_\_

Mobile: \_\_\_\_\_

Email id: .....



## **ACKNOWLEDGEMENT SLIP**

**Policy No.:**

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**Name of Claimant:** .....

**Interaction ID:**.....

Documents Submitted: Please Tick

- Attested Death Claim Form and Signed by the Claimant
- Original Death Certificate or attested copy thereof issued by Municipal Authorities
- Original Policy Document (s)
- Copy of Claimant's current address proof
- Copy of Claimant's Photo Id proof which establishes relationship with life assured
- Last Medical Attendant Report
- Medical Records
- Employer's Questionnaire
- Copy of First Information Report (FIR)
- Copy of Post Mortem Report, Viscera Report
- Inquest Panchanama
- Policy Final Investigation Report
- Newspaper Cutting

**BRANCH STAMP WITH RECEIPT DATE**

**Processed by (Name & Signature):**

Claim Contact Points

<b>Mailing Address:</b> Aviva Life Insurance Company India Ltd. 3 <sup>rd</sup> Floor. Aviva Towers, Sector-43, Opposite DLF Golf Course, Gurgaon-122003 Haryana	<b>For any urgent queries contact:</b> Customer service Helpline Number 1800-180-22-66 (Toll Free)  0124-2709046	<b>For any queries please write to:</b>  claims@avivaindia.com
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