

LIFE INSURANCE CORPORATION OF INDIA
“DIVISION OFFICE SHIMLA”

CLAIM FORM

CLAMING BENEFITS PAYABLE UNDER GROUP SAVING LINKED INSURANCE SCHEME

MASTER POLICY No. 78006

(To be completed by the Grantees) D.O.C.:20-10-1987

1	Name of Institution	:	CSK HP Krishi Vishvavidyalaya, Palampur
2	Master Policy No. GSLIS/78006	:	
3	Name of the Insured Member	:	
4	Employees/assurance No./Sr. No. in the list	:	
5	Category/Salary Grade	:	
6	Amount of Insurance Cover	:	
7	Date of Birth	:	
8	Date of Entry in the Scheme	:	
9	Amount of Monthly Contribution recovered from the Insured member	:	
10	If there has been a change in the monthly contribution during the member ship, indicate dates of change and the revised contribution	:	
11	Due date of payment of first contribution (Indicate day, month & Year)	:	
12	Date of exit from the Scheme	:	
13	Due date for the payment of last contribution (Indicate day, month & Year)	:	
14	The date on which the last contribution was paid to the corporation	:	
15	Mode of Exit (Death/Retirement/Resignation, Termination of Service)	:	
16	Cause of Death (In case of exit by death)	:	
17	Was the member absent on ground of ill health on the date of entry in to the Scheme (if so, give detail of leave)	:	
18	Name of beneficiary and relationship to the member (In case of death)	:	
19	Nature of proof of death (Please enclose original death certificate)	:	
20	Whether any premium remains unpaid during membership, if so, give details	:	

We declare that the above particulars are true and correct and the above member was an insured member covered under the scheme on the date of his exit and that all premium have been paid to the corporation on his behalf.

Head of Department/Station (Office Stamp)

We confirm that beneficiary mention above is the person appointed by the member to receive the benefit under the Scheme.

Dated at _____ this _____ day of _____

WITNESS:

Signature: _____

Name: _____

Address: _____

Signature of the Master Policy Holder

Discharge Receipt

Received a sum of Rs. _____
(Rs. _____)
from the Life Insurance Corporation of India in full and final settlement of all our claims and demands in respect of
Shri / Smt. _____ Insurance No. _____
under Master Policy No. _____ who expired / Left Service / retired on _____ .

Signature of the authorized signator

Name : _____

Designation: _____

(OFFICE STAM)



WITNESS:

Signature: _____

Name: _____

Designation: _____

Address: _____
