CIC LIFE ASSURANCE LTD
We keep our word

EMPLOYEE GROUP LIFE CLAIM FORM

(Please complete this form and return it to us promptly. All questions must be fully answered. Blanks are not accepted)

INSURED Name ----------

Address----------

CLAIM FOR Name: ----------

Address: ----------

Date of birth----------

Payroll/M No. ---------- ID No----------

Date last in full time active employment----------

Was claimant in the payroll at the time of loss? Yes ☐ No ☐

If No, give reason----------

Monthly salary at the time of loss ----------

If there is no designation of beneficiary apply the provision of the policy No ----------

BENEFITS PAYABLE TO:

Name----------

Address----------

Relationship----------

Date of decision ---------- Signature ----------

CLAIMS SUPPORTING DOCUMENTS

1. Completed claim form
2. Original death certificate
3. Doctor's Medical report (in case of critical illness)
4. Copy of ID card
5. Last pay slip/certificate of earnings (for salary based benefits)