

Beneficiary Information:

- 1) Beneficiary Name: _____ 2) Relation with the Deceased: _____
- 3) Address: _____
- 4) Bank Name: _____ 5) Account Type: _____
- 6) Account No.: _____ 7) IFSC Code: _____
- 8) Contact No.: _____ 9) E-Mail ID: _____

Declaration & authorization by beneficiary/beneficiaries

I/We, the above mentioned claimant/s do solemnly declare the foregoing statements are true & agree that furnishing this form, or any other form supplemental thereto, shall not constitute an admission by it that there was any insurance in force on the life in question or a waiver of any rights or defense. We agree that submission of this form will not be construed as acceptance of claim by Bandhan Life Insurance Limited. I/we hereby give our / my consent to Bandhan Life Insurance Limited. and/or its representative to obtain all past / present employment/birth & death registrar / medical / Govt. or Pvt Hospital records / Police records / other records (including photocopies) / information pertaining to the treatment/occupation of the deceased and/ or conduct such investigations as it may deem fit. We agree that payment of claim amount shall constitute discharge of liability of Bandhan Life Insurance Limited.

Signature of Claimant/Beneficiary

Name: _____

Date: _____

Signature of Authorized Signatory with Company Seal

Name & Designation _____

Date: _____

Vernacular Declaration (if the Claimant signs in vernacular or affixes thumb impression, the witness should also sign the following declaration):

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

Signature of the Witness: _____

Address: _____

Name of the Witness: _____

Contact No. of the Witness: _____

Note: Witness declaration to be signed by any of these: Official of MPH or any other person of local standing / Special Executive Magistrate / Notary / Lawyer / Class 1 Gazette Officer



Bharat Ki Udaan, Bandhan Se.



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