



CUSTOMER SERVICE REQUEST FORM

(PLEASE (✓) TICK THE APPROPRIATE BOX FOR THE PURPOSE THIS SERVICE REQUEST)

1. **Change in -- Address/Contact Details Request;** Please write in (BLOCK LETTERS)

Address _____

City _____
State _____ Pin _____

Contact Details

Office: STD _____ Tel _____
Residence: STD _____ Tel _____
Mobile _____
E-mail _____

2. **Change in Name Request:** Policy Owner Life Insured (Please tick the box)

(First Name) (Last Name)

Note: Please provide us with a certified copy of the supporting document along with the Affidavit

3. **Change in Nominee Name Request:**

From (Current Nominee)	To (Proposed Nominee)	Date of Birth of nominee, if minor (dd/mm/yyyy)	Relationship With Life Insured	Appointee details (if nominee is minor)

Note: If nominee is a minor, please name a person ("Appointee") to receive policy proceeds in the event of death of the life insured, while the nominee is still a minor. If the nominee is a minor (i.e. under 18 years) please provide details of the Appointee-

Appointee Details

First Name _____

Last Name _____

Address _____

City _____
State _____ Pin _____

Relationship of Appointee with Nominee: _____

Signature of Appointee: _____

4. **Partial Withdrawal Request: (applicable only after third policy anniversary)**

The policyholder may at any time after the third policy anniversary, can request and partially withdraw from the policy to an extent not exceeding 30% of the policyholders' account value prevailing as on the immediately preceding policy anniversary. This will be subject to a partial withdrawal charge as applicable.

Amount (in Rs.) _____ Amount (in words): _____

5. **Full Surrender of Policy Request:**

The policyholder may surrender the policy at any time after the third policy anniversary. A surrender value equal to the policyholder's account values less the surrender charge shall be paid to the policyholder.

Note: Kindly attach the original policy pack and the first premium receipt along with this service request form

6. **Free Look Cancellation Request:**

The policyholder has a period of 15 days from the date of receipt of the policy to review the terms and conditions thereof and if the policyholder disagrees to any of the said terms and conditions, he has the option to return the policy stating the reasons for his objection/cancellation

REASON FOR CANCELLATION: _____

Note: Kindly attach the original policy pack and the first premium receipt along with this service request form

FOR ANY OF THE ABOVE POINTS 4, 5 AND 6, PLEASE FILL THE BANK DETAILS BELOW:

Bank Name:	Bank Account Number:
MICR Code:	IFSC Code:
Name of Policy Holder: (Mention complete name)	Signature of the Policy Holder: (Should match with policy records)
Date:	Place:



Application Form for Death Claim -- Claimants Statement

(To be filled in by the person legally entitled to the policy money. All the answers must be clear & unambiguous.)
PLEASE SEND IN THE DOCUMENTS AS PER THE CHECKLIST PROVIDED (at the bottom of the page)

Policy No:

Claimant Contact No:

I. Information about the Claimant

Name of the Claimant(s) _____ Complete Address _____
 _____ Age of Claimant _____

1. Bank Details (Mandatory) Bank Name _____ Bank Account No: _____

II. Information about the Life Insured

Name _____ Age _____ Place of Death _____ Date and Time of Death _____

2. (a) Cause of Death: Medical Accident Suicide 2. (b) Duration of last Illness

3. If Medical, please specify the cause of death _____

4. When did the deceased first take treatment for the illness, which eventually caused his death?
 a) Date and type of illness _____ b) Kind of treatment given _____

5. Name and address of the Doctor(s) consulted during the last illness: _____

1.a) Tel. No.: Clinic _____ b) Mobile _____ c) Resi _____

2.a) Tel. No.: Clinic _____ b) Mobile _____ c) Resi _____

Please complete the following (if applicable):

6. Name of Police Station (where death was recorded). FIR No.....FIR Date.....

7. Name of Hospital (where Post Mortem was conducted).....

Post Mortem No..... Date of Post Mortem

III. Information about the Life Insured

I/We, the above-named claimant(s), do solemnly declare that the foregoing answers and statements are true in all respects, and further agree that the furnishing of this form, or any other form supplemental thereto, to the Company, shall not constitute an admission by the Company that there was any insurance in force on the life in question or a waiver of any rights or defence.

Notwithstanding, any law, custom or usage, prohibiting the furnishing of secret information obtained during the medical treatment / investigation of Life Insured, I/We hereby authorize any doctor or other person, or any hospital, sanatorium, medical professional, hospital or other medical care institution, insurance support organization, pharmacy, governmental agency, insurance company, employer, benefit plan administrator, accountant, or financial adviser or other institute to provide to MAX NEW YORK LIFE INSURANCE COMPANY LTD., any of its offices, or Court of Law, or any investigative agency or independent administrator acting on its behalf, information concerning employment, finances or insurance, advice, care or treatment provided to deceased, or any information that may be required concerning the health of the deceased (Life Insured) including information relating to mental illness, use of drugs, use of alcohol, HIV(AIDS Virus) and /or sexually transmitted diseases. A Photostat copy of this authorization shall be considered as effective and valid as the original.

Signature of Claimant _____ Signed at (Place) _____ Date _____

Signature of Witness- Mandatory

Signature: _____

Name: _____

Address: _____

Phone No (With Std Code) _____

The form must be witnessed by any one of the following: (1) An Agent (2) Sales Manager / Branch Manager of the company (3) Block Development officer, (4) A Bank Manager of a Nationalized bank with Rubber Stamp, (5) An officer of the Company not below the rank of Manager, (6) A Gazetted Officer, (7) A Head Master / Principal of a Govt. School, (8) A Magistrate.

Declaration in case of an illiterate Claimant where his/her left thumb impression should be made by a person of standing unconnected with the company and whose identity can be easily established.

"I hereby certify that the contents of above form are explained by me in the Language understood by the Claimant and that he/she has affixed his/her thumb impression to this form after fully understanding the contents thereof."

(Full Signature of the Witness)

NOTICE: Any person who knowingly files a claim containing false or misleading information, or who conceals information with intent to defraud or mislead the Company or other person, may be guilty of felony or subject to other criminal and/ r civil penalties as the case may be under the applicable law(s) of the State.

Checklist of Documents to be attached-

1) Death Certificate 2) Original Policy pack 3) Claimant Photo ID Proof 4) FIR, Panchnama and Post Mortem Report (If death due to accident)