



APOLLO LIFE ASSURANCE • LIMITED

Apollo Life ... for a Better Life

GROUP LIFE ACCIDENT & DISABILITY ASSURANCE CLAIM FORM

Full Name of Deceased _____

Company Name _____

Occupation at time of Death _____

Date of Death _____

Place of Death _____

Cause of Death _____

Next of Kin _____

Documents required

- | | | |
|----|---|--------------------------|
| 1. | Copy of Death Certificate/Burial Permit | <input type="checkbox"/> |
| 2. | Copy National Identity Card | <input type="checkbox"/> |
| 3. | Copy of last monthly pay-slip | <input type="checkbox"/> |
| 3. | Doctors Report in case of Disability | <input type="checkbox"/> |

I hereby undertake that aforementioned information and attached statements are true and complete to the best of my knowledge and hence authorize you to settle the claim in the name indicated above as next of kin.

DATED _____

FULL NAME OF EMPLOYER _____
(Rubber Stamp)

NAME: _____

POSITION _____

SIGNATURE: _____