

Filled Death Claim Form Sample for Medical Insurance

Review this **filled death claim form sample** to understand the proper completion process for medical insurance claims. It provides a clear example of the necessary details required by insurance providers. Use this sample as a guide to ensure accurate and timely claim submissions.

Policyholder Information

Policy Number: MI-123456789

Full Name of Deceased: John Albert Smith

Date of Birth: 12/04/1962

Address:

123 Main Street, Springfield, State, 600123

Claimant Information

Claimant Name: Mary Smith

Relationship to Deceased: Spouse

Contact Number: +1-123-456-7890

Claimant Address:

123 Main Street, Springfield, State, 600123

Details of Death

Date of Death: 20/01/2024

Cause of Death: Heart Attack

Place of Death: Springfield General Hospital

Attending Physician: Dr. Emily Green

Bank Details for Claim Payment

Bank Name: Springfield National Bank

Account Holder's Name: Mary Smith

Account Number: 3456789123

IFSC / Routing Code: SPRING123

Supporting Documents Attached

- Original Policy Document
- Death Certificate (No. DC2024/0198)
- Medical Certificate of Cause of Death
- Copy of Claimant's ID Proof
- Bank Passbook Copy

Declaration

I, Mary Smith, hereby declare that the information provided above is true and complete to the best of my knowledge. I request the insurance proceeds be released as per policy terms.

Signature of Claimant:

Date: