

्राप्तिंग.मिज.येथ.मिट.जय.यहूब.क्री

ROYAL INSURANCE CORPORATION OF BHUTAN LTD.

HEAD OFFICE: THIMPHU

DEATH CLAIM FORM – TMN-II

	Master Policy No.						Date				
Name of Proposer CID # Sum Assured Period of Insurance From To To Contact No # Address CID # Address A	Branch Name										
Name of Proposer CID # Sum Assured Period of Insurance From To To Contact No # Address CID # Address A	Life Insurance Proposer's details										
Period of Insurance From To											
2. Claimant Details Name of Claimant CID # Address 3. Death Details Date and Time of Death Cause of Death Date and Time of accident Place of Accident Place of Accident Place of Macro who treated the deceased Hospital Address I,	CID#			Personal No.							
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CID # Contact No # Address 3. Death Details Date and Time of Death Place of Death Cause of Death If Death due to accident Date and Time of accident Place of Accident If Death due to illness Type of Illness Doctor who treated the deceased Hospital Address I,	2. Claimant Details										
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3. Death Details Date and Time of Death Cause of Death If Death due to accident Date and Time of accident Place of Accident If Death due to illness Type of Illness Hospital Address I,	CID#					Contact N	lo#				
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Date and Time of accident Place of Accident	Cause of Death										
Type of Illness Type of Illness Hospital Address I,	If Death due to accident										
Type of Illness Doctor who treated the deceased	Date and Time of a	accident									
Hospital Address I,											
I,	Type of Illness										
each and all the above questions are full and true in each and every respect. Signature of Claimaint Seal & Signature of Employer Name CID # CID #	Hospital Address										
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Signature of Claimaint Seal & Signature of Employer Name CID # CID #	I,										
Claimaint of Employer Name Name CID # CID #	each and all the above questions are full and true in each and every respect.										
CID# CID#											
	Name				Name						
Place and Date Place and Date	CID#				CID#						
	Place and Date				Place and [Date					

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