



The strength behind your insurance

CLAIM FORM - DEATH

A. DECEASED'S PARTICULARS

Name of Policyholder: _____ Policy No.: _____

Name of Deceased: _____ Member No.: _____

Sex: _____ Age: _____ Date (day/month/year): _____ Passport/ I.D. No.: _____

Occupation prior to death: _____

Residence prior to death: _____

Name & Address of Employer prior to death: _____

Name & Address of the Deceased's Attending Physician: _____

B. PARTICULARS OF THE DEATH

(For death due to accident, please complete questions 1-2 below)

1. When and where did the accident occur?

2. How did the accident occur?

(For death due to sickness, please complete questions 3-5 below)

3. a. Give a brief description of Insured Person's symptoms

b. How long had he/she been experiencing these symptoms prior to death?

4. Date and cause of death

5. Give details of consultations

a. The attending physician first consulted for this illness.

Date _____ Name(s) and Address(es) of Attending Physician(s)/ Hospital(s) _____

b. The attending physician who referred the Insured Person to hospital

Date _____ Name(s) and Address(es) of Attending Physician(s)/ Hospital(s) _____

c. All other physicians consulted during this Illness

Date _____ Name(s) and Address(es) of Attending Physician(s)/ Hospital(s) _____

d. Physicians seen for any similar condition in the past

Date _____ Name(s) and Address(es) of Attending Physician(s)/ Hospital(s) _____

C. OTHER INSURANCE COVERAGE

Was the life of the deceased insured with other insurance company? Yes No

If "Yes", please state:

Name of Company: _____ Policy No.: _____ Amount of Assurance: _____

D. INFORMATION OF CLAIMANT

Name: _____ Passport/ I.D. No.: _____

Sex: _____ Age: _____ Date of Birth (day/month/year): _____

Address: _____ Tel: _____

_____ Fax: _____

_____ Email: _____

Relationship with the Deceased: _____

1. Are you one of the named beneficiaries? Yes No

If "no", in what capacity or by what title do you claim this assurance?

2. Who has possession of the policy document?

AUTHORIZATION

I hereby irrevocably authorize any employer, physician, clinic, insurance company, government office or any organizations or persons who have any records, knowledge or information (whether medical or otherwise) of the Deceased to disclose, release or transfer to the insurance company or its representative such information pertinent to this claim. This authorization shall bind my successors and assignees and remain valid notwithstanding my death or incapacity in so far as legally possible. A photocopy of the Authorizations shall be valid as the original.

Signature of Claimant/ Beneficiary: _____ Date (day/month/year): _____