CLAIM FORM - DEATH

PACIFIC CROSS

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 for as legally possible. A photocopy of the Authorizations shall be valid as the original.

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