AVIVA

AVIVA LTD
Customer Service, Group Life & Health Claims (Fax: 6827 7705)
Customer Service, Individual Life Claims (Fax: 6827 7900)
4 Shenton Way, #01-01 SGX Centre 2, Singapore 068807
Tel: 68277 988
Company Registration No.196900499K

DEATH CLAIM FORM – CLAIMANT'S STATEMENT

Please specify ☑ policy type of which you are filing the death claim: ❒ **Individual** ❒ **Group**

Please refer to instructions under **How to file a Death Claim** before completing this form **POLICY NUMBER(S):** ____________________

SECTION I

1) Name of Policyholder	I.C/Passport/B.C No.	Religion	Marital Status	Date of Birth	Sex
2) Name of Deceased (if other than Policyholder)	I.C/Passport/B.C No.	Religion	Marital Status	Date of Birth	Sex
3) Relationship of Deceased to Policyholder	4) Sum Assured in respect of Deceased				
5) Place of Birth of Deceased	6) Resident at Time of Death				
7) Date of Death	8) Place of Death				
9) Cause of Death	10) Was the Cause of Death Work-Related ❒ Yes ❒ No		11) Occupation of Deceased		

12) If Cause Of Death Is A Result Of Illness, Please State
a) Date Illness First Commenced: b) Date First Treated:

13) If Cause Of Death Is A Result Of Accident, Please State
a) Date of Accident b) Description of Accident:

14) Was a Post-Mortem or Autopsy carried out? ❒ Yes ❒ No If "Yes", please submit a certified true copy of the report

15) Name And Address Of All Physicians Who Attended During His/Her Last Illness/Injury

a) Name & Address	b) Date First Attendance	c) Illness

(NOTE: THIS SECTION IS FOR GROUP POLICYHOLDERS ONLY)

1) Name of Employer/Policyholder

2) If Sum Assured is Based on Salary, Please Furnish a certified True Copy (by employer) of The Insured Member's Last Pay Slip (for a full month).
a) Last Drawn Salary: b) Date of Last Drawn Salary:

3) Date of Employment 4) Commencement Date of Insurance for Insured Member

5) If deceased is a dependant, effective date of his/her insurance

I ....(NRIC/PP No...) the undersigned, do solemnly and sincerely declare that the answers given to the above questions are true to the best of my knowledge and belief and that no material fact has been concealed from the Company and I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the Statutory Declaration Act, 1835.

Signature of Employer ____________ Company's Name and Stamp ____________ Date (DD/MM/YY) ____________

(NOTE: THIS SECTION IS FOR INDIVIDUAL POLICYHOLDER ONLY)

1) Has Deceased Left A Will? ❒ Yes ❒ No If "Yes", please submit a certified true copy of the Last Will & Testament

2) Who Are The Surviving Family Members Of the Deceased?

3) In what Capacity or by what Title do you claim the Assurance? Please indicate your relationship with the Deceased:

4) Is the Deceased insured with other Insurance Company? ❒ Yes ❒ No
If "Yes" (a) Name of Insurance Company: (b) Policy No.:

I ....(NRIC/PP No...) the undersigned, do solemnly and sincerely declare that the answers given to the above questions are true to the best of my knowledge and belief and that no material fact has been concealed from the Company and I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the Statutory Declaration Act, 1835.

I further hereby consent to AVIVA LTD seeking information from any hospital, physician, person or organisation that may be required regarding the abovenamed deceased and I authorize the giving of such information to Aviva Ltd. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Claimant : ____________ Signature of Witness : ____________
Name of Claimant : ____________ Name of Witness : ____________
NRIC No. : ____________ NRIC No. : ____________
Address : ____________ Date : ____________
Telephone no. : ____________

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DEATH CLAIM FORM – PHYSICIAN'S STATEMENT

SECTION II – To be completed by Attending Physician. The medical report fee, if any, will be borne by the Claimant.

1) Name of Deceased	I.C/Passport/B.C. No.	Occupation

2) Name of Deceased's Company

3) Is The Photograph in the I.C./Passport/B.C that of the deceased?

4) Date of Death

5) Place of Death

6) What was the Immediate Cause of Death?

7) How long has the illness been existing prior to Death?

8) Did Deceased have any symptoms prior to Death?

Yes ☐ Date symptoms first started:

Nature of Symptoms:

No ☐

9) When did Deceased first consult you for this condition?

Date:

When did Deceased last consult you for this condition?

Date:

10) Nature of Treatment rendered

11) Date of Treatment rendered

12) When was the diagnosis leading to the cause of Death first diagnosed?

13) Was the Deceased informed of the diagnosis? ☐ Yes ☐ No

If "Yes", when was the Deceased first told?

14) Did Deceased suffer from any other illness?

Illness	Period of Illness	Date of Diagnosis	Date & Type of Trearment

15) Was the Death in any way partly attributed to Deceased's habits, family history, occupation OR previous diseases? ☐ Yes ☐ No

If "Yes", give details.

16) Doctors previously consulted by Deceased for the above condition?

	Name	Approximate Date	Name of Clinic	Address
(1)				
(2)				
(3)				

I ……………………………………………………………………………………………….the undersigned, do hereby declare that I was the physician in attendance during the last illness of

………………………………………………………………………… and that the foregoing answers are true to the best of my knowledge and belief and that no material fact has been concealed from the Company.

Date : ____________________

Signature : ____________________

Professional Qualification : ____________________

____

Clinic or Hospital Stamp

Postal Address : ____________________

____

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CLINICAL ABSTRACT APPLICATION (FOR INDIVIDUAL POLICY ONLY)

To whom it may concern:

____
____
____
____

Dear Sir/Madam

Please furnish **AVIVA LTD** with a detailed medical report on:

____ NRIC / BC ______________________
(Name of Patient)

This report is required for insurance purposes. Upon receipt of this application from **AVIVA LTD**, you may furnish a detailed medical report (together with histology report, laboratory results, etc.) whether for use in connection with litigation or for other legitimate purposes.

I agree that a copy of this authorisation form shall be considered as effective and valid as the original.

____

Signature of Next-Of–Kin

Name : ____________________________________

Address : ____________________________________

____

NRIC No : ____________________________________

Date : ____________________________________

Relationship to Patient / Deceased : ____________________

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INSTRUCTIONS

HOW TO FILE A DEATH CLAIM

For Group Policy Holder, please furnish the following documents: -

(1) Claimant's Statement (to be completed and signed by the Authorised Officer of the Company)
(2) Physician's Statement (to be completed by the attending Physician who attended the deceased in his last illness or accident. Cost of the Physician's Statement is to be borne by the Claimant.)
(3) Certified true copy of the Death Certificate
(4) Certified true copy of the Birth Certificate of the deceased
(5) Certified true copy of Marriage Certificate

If death is resulted from accidental or violent causes, the following additional documents are required:

(1) Police Investigation Report
(2) Coroner's Inquest
(3) Post Mortem / Autopsy Report
(4) Toxicological Report

For Individual Life Policy Holder, please furnish the following documents (where applicable): -

(1) Claimant's Statement (to be completed by the Claimant)
(2) Certified true copy of the Death Certificate
(3) Certified true copy of the Birth Certificate of the deceased
(4) Original Insurance Policy or Certificate of Insurance
(5) Certified true copy of Marriage Certificate
(6) Certified true copy of the Birth Certificate of the Claimant(s)
(7) Certified true copy of the identification (NRIC, Passport, etc) of the Claimant(s)
(8) Original Assignment Form
(9) Clinical Abstract Application
(10) Completed Physician's Statement
(11) Any other documents that support the claim

If death is resulted from accidental or violent causes, the following additional documents are required:

(1) Police Investigation Report
(2) Coroner's Inquest
(3) Post Mortem / Autopsy Report
(4) Toxicological Report

IMPORTANT NOTE: We reserve the right to pursue for any documents that are not mentioned above if they are deemed necessary. These said documents shall be in the forms as prescribed by Aviva Ltd and shall be furnished at the expense of the Claimant(s). The cost of the Physician's Statement and/or medical evidence shall be borne by the Claimant(s).