Singlife

SINGAPORE LIFE LTD.
Group Life & Health Claims
4 Shenton Way, #01-01 SGX Centre 2
Singapore 068807
Tel: 6827 8030
Company Registration No.196900499K

DEATH CLAIM FORM
CLAIMANT'S STATEMENT

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 NRIC/passport of the deceased
(5) Certified true copy of Marriage Certificate(if the deceased is the spouse of the employee) or Birth Certificate (if the deceased is the child of the employee)

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

SECTION I – To be completed by the Company and Claimant

Name of Company : _____ Policy No : _____

To Be Completed By Claimant

1) Name of Employee	NRIC/Passport/BC No	Occupation	Marital Status	Date of Birth	Gender ☐M ☐F
2) Name of Deceased (if other than Employee)	NRIC/Passport/BC No	Occupation	Marital Status	Date of Birth	Gender ☐M ☐F
3) Relationship of Deceased to Employee	4) Place of Birth of Deceased				
5) Resident at Time of Death	6) Place of Death				
7) Date of Death	8) Cause of Death		9) Was the cause of death work related? ☐ Yes ☐ No		

10) If Cause of Death is A Result of Illness, Please State
a) Date Illness FIRST Commenced: b) Date First Treated:

11) If Cause of Death is A Result of Accident, Please state
a) Date of Accident: b) Description of Accident:

12) Was a Post Mortem or Autopsy carried out? ☐ Yes ☐ No
If Yes, Please submit a certified true copy of the report

13) Name & Address of All Physicians Who Attended During His / Her Last Illness / Injury

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

To Be Completed By The Company

1) Sum Assured in respect of Deceased
2) Plan

3) If Sum Assured is Based on Salary, Please Furnish a certified True Copy (by employer) of The Insured Member's Last Pay Slip (for last 3 months).
a) Last Drawn Salary: b) Date of Last Drawn Salary:

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

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

This part must be signed by the patient's parent / legal guardian if patient is below 21 years old.
I/We hereby authorize Singapore Life Ltd. ("Singlife") **to request from any hospital, physician, person or organization, all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records concerning the patient at any time and authorize the prior mentioned organizations to disclose all such information to** Singlife**. A photocopy of this authorization shall be considered as effective and valid as the original.**
I/We declare and undertake that I/we have submitted the actual bills and receipts (including electronic/digital copies) issued by the medical institutions.
I/We understand that Singlife has the right to:
- Ask for originals/certified true copies of the bills and receipts, or contact the medical institution directly, to confirm that the bills and receipts are original.
- Reject claims, recover amounts paid or impose additional charges, if the claims is false or where there are multiple claims made.

I/We declare that the statements and answers stated are true and complete to the best of my/our knowledge and belief.
I/We consent to Singapore Life Ltd. ("Singlife") (and Singlife related group of companies) **collecting, using and/or disclosing my/our personal data for the processing of the above transaction and such other purposes ancillary or related to the administering of the policy(ies), account(s) and/or managing my/our relationship with** Singlife.
I/We also consent to Singlife (and Singlife related group of companies) **transferring my/our personal data to** Singlife (and Singlife related group of companies) **and their respective third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.**
I/We have read and understood Singlife**'s Data Protection Policy which may be found at** www.singlife.com/pdpa**.** Singlife**'s Data Protection Policy may be updated from time to time without notice.** I/We am/are aware that I/we should visit your website regularly to ensure that I/we am/are well informed of the updates.

Signature of Claimant : _____
Name of Claimant: _____
NRIC No: _____
Relationship of Claimant to Deceased: _____
Address : _____

Signature of Employer: _____
Company's Name & Stamp: _____
Date: _____
Telephone No: _____

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DEATH CLAIM FORM
CLAIMANT'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	NRIC/Passport/BC No	Occupation
2) Name of Deceased's Company	3) Is The Photograph in the NRIC / Passport that of the deceased?	
4) Date of Death	5) Place of Death	
6) What is 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: _____ ☐ No	9) When did Deceased first consult you for this condition? Date:_____ When did Deceased last consulted 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 Treatment

15) Had the illness / injury prevented the Deceased from working? ☐ Yes ☐ No
If Yes, please indicate the medical leave / hospitalisation leave period the Deceased was away from work:

16) Was the Death in any way partly attributed to Deceased's habits, family history, occupation or previous diseases? ☐ Yes ☐ No
If Yes, please provide details:

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

Name	Approximate Date	Name of Clinic	Address

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:_____

Postal Address: _____

_____

_____

_____
Clinic or Hospital Stamp

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 Singapore Life 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).