Etiqa Insurance Pte. Ltd. (Company Reg. No. 201331905K)
One Raffles Quay #22-01 North Tower Singapore 048583 | T +65 6336 0477 | F +65 6339 2109 | www.etiqa.com.sg

DEATH CLAIM FORM

Section A

Every question must be fully answered and the Company reserves the right to require further information should it deem necessary. Submission of this Claim Form does not guarantee admission of liability.

Policy Number	
Representative's Name	
Representative's Code	Branch
Representative's Contact Number	

Instructions – Supporting documents required

All Submitted documents have to be Certified True Copy by Etiqa's Representatives or Customer Care Officers

- ☐ Death Claim Form
- ☐ Death Statement of Medical Examiner (for policy duration < 5 years)
- ☐ Certified Copy of Deceased IC or Passport
- ☐ Certified Copy of Claimant's IC or Passport
- ☐ Certified Copy of Death Certificate
- ☐ Certified Copy of Burial Certificate or Cremation Documentation
- ☐ Original Certificate/Policy Contract
- ☐ Certified Copy of Proof of Relationship between Claimant and Deceased
- ☐ Attending Physician Statement

Additional requirements on accidental death

- ☐ Detailed Post Mortem Report
- ☐ Certified Copy of Toxicology Report, if any
- ☐ Certified Copy of Police Investigation Report
- ☐ Newspaper Cutting, if any

Additional requirements for death in overseas

- ☐ Confirmation letter from National Registration of Singapore
- ☐ All relevant documents issued by Foreign Authority must be certified by Singapore Embassy or Public Notary

Method of delivery for claims settlement

☐ Mail ☐ Self Collection ☐ Collection by Representative ☐ Auto Credit

1. Details of Deceased

Name of Deceased	
NRIC / Passport Number	
Date of Birth	
Last Address of Deceased	
Marital Status	
What family has the Deceased left?	☐ Spouse ☐ No of Child _____ ☐ Parent ☐ Others, please specify _____

2. Details of Employer

Name of the Employer of Deceased at the time of death	
Address of Employer	
Office Telephone Number	
Date of Employment (dd/mm/yyyy)	
Is the death related to the work?	☐ Yes ☐ No

3. Details of Claimant

Name of Claimant		
NRIC / Passport Number		
Date of Birth		
Correspondence Address		
Contact Number	1	2
Email Address		
What is your relationship with the Deceased?		
Is there any Will related to beneficiary?	☐ Yes, please provide true copy of the Last Will, if available ☐ No	

4. Particulars of Death (due to Illness)

Date of Death (dd/mm/yyyy)	
Time (am / pm)	
Cause of Death	
Place and Country of Death	
When did Deceased **first** complain of or give indication of his / her last illness? (dd/mm/yyyy)	
When did Deceased **first** consult a Physician for his / her last illness? (dd/mm/yyyy)	
Name & address of doctor Deceased first consulted for his / her last illness	
State the name and address of Deceased's regular doctor	

Please state names and address of every physician who attended to the Deceased during his / her last illness

Date Consultation (dd/mm/yyyy)	Date of Admission (dd/mm/yyyy)	Date of Discharge (dd/mm/yyyy)	Diagnosis	Name of doctor & address of hospitals/clinics

5. Particulars of Death (due to Accident or Unnatural Cause)

Date of Accident (dd/mm/yyyy)	
Time (am / pm)	
Place of Accident	
Why was the Deceased at the location?	
Describe in detail how the Accident happened?	
Was the accident reported to the police?	☐ Yes ☐ No (If Yes, please submit a certified copy of police investigation report)
Was the accident reported in the newspaper?	☐ Yes ☐ No (If Yes, please submit a copy)
Was an inquest or post-mortem carried out?	☐ Yes ☐ No (If Yes, please submit a certified copy of post mortem report)

5. Are there other policies in force on the Deceased's life taken with other companies?

☐ Yes ☐ No

If Yes, please furnish the following details:

Name of Company	Commencement Date (dd/mm/yyyy)	Policy Number	Type of Coverage	Sum Assured

6. Please state your (the Claimant) bank account details in order for us to credit the payment directly into your bank account.

Bank	
Account Number	
Identity Card Number (as per bank account)	

Claimant's Declaration and Authorisation

I/We hereby declare that I/we are duly authorised to make this claim and all statements and responses whether on this form or otherwise together with any required questionnaire, amendments, materials and supporting documents submitted in connection with the claim and the Policy ("Information"):

a) declare that all Information is complete, true and correct and that no information or materials have been withheld and that Etiqa Insurance Pte. Ltd. will rely and act on the Information accordingly. Otherwise, Etiqa Insurance Pte. Ltd. shall be at liberty to deny liability or recover amounts paid, whether wholly or partially;
b) acknowledge and accept that Etiqa Insurance Pte. Ltd. shall be at liberty to deny liability or recover amounts paid, whether wholly or partially, if any of the Information is incomplete, untrue or incorrect in any respect or if the Policy does not provide cover on which such claim is made; and
c) acknowledge and accept that Etiqa Insurance Pte. Ltd. expressly reserves its rights to require or obtain further information as it deems necessary.

Data Protection and Consent for Use of Information

I/We give consent to Etiqa Insurance Pte. Ltd. to collect, use, disclose and/or process my/our personal data/personal information set out in this form and any other personal information provided by me/us (collectively the "Personal Information") and disclose and transfer such Personal Information to any persons and organisations, whether within or outside Singapore, including but not limited to medical sources, hospitals, doctors, other healthcare professionals, laboratories, regulator, dispute resolution centres and insurers, their associated persons/organisations, my/our or the insured person's employers or financial service providers, or their third party service providers or representatives (collectively "Third Parties") for the purpose(s) of:

a) processing, handling and/or dealing with my claims including the settlement of the claims and any necessary investigations relating to the claims;
b) carrying out and/or dealing with my instructions or responding to any enquiries by me;
c) administering my claims (including the mailing of correspondence, statements, invoices, reports or notices to me, which could involve disclosure of certain personal data about me to bring about delivery of the same as well as on the external cover of envelopes/mail packages); and/or
d) complying with applicable law in administering, processing, handling and/or dealing with my claims.
(collectively the "Purposes")

US Tax Declaration & Acceptance

By ticking the appropriate box, I/We declare my tax status under United States ("US") tax law. I/We understand that a false statement or misrepresentation of tax status by a US person (for the purpose of US federal income tax) ("US Person") leads to penalties under US law.

☐ Non-US Person
I/We represent and warrant that I/we am/are not US Person, and I/we am/are not acting for, or, a US Person. If my/our tax status changes and I/we become a US Person, I/we agree that I/we shall notify the insurance company(ies) within 30 days from the date of change.

☐ Non-US Person with US Address (or green card holder claiming tax treaty benefits) (Form W8BEN)

☐ US Person (US Tax ID Number: _____) (Form W9)

I/We agree to indemnity Etiqa in respect of any false or misleading information regarding my/our US tax status.

_____

US citizens/residents, please sign here

_____	_____
Signature of Claimant	Signature of Witness
Name : _____	Name : _____
Contact Number : _____	Contact Number : _____
Date : _____	NRIC / Passport Number : _____
	Relationship to Claimant : _____
	Date : _____

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LETTER OF AUTHORISATION / CONSENT

To obtain further information (Death Claim)

Policy Number

TO WHOM IT MAY CONCERN

I hereby authorise and give my consent to any medical practitioner, physician, surgeon, clinic, hospital, medical centre, insurance company or other organisation, institution or individual concerned ("the Information Provider(s)') that may have any records or knowledge of the employment, financial, health or medical history of

_____ (Name of Deceased), _____ (NRIC, Passport Number) and to provide such information to Etiqa Insurance Pte.Ltd. or its authorised agents and / or employees.

I expressly waive on behalf of myself and / or as a next-of-kin of the Life Assured and for his / her estate all provisions of law or professional ethics forbidding the Information or (Providers) from disclosing any such information acquired on the Life Assured in a professional and / or client capacity and I further release the Information Provider(s) and its agent / staff from any liability whatsoever that may arise, in supplying such information requested by the Company.

This authorisation / consent is irrevocable and a copy of it will have the same effect and validity as the original.

_____

Signature / Thumb print of Next-of-Kin / Claimant

Name : _____

NRIC / Passport Number. : _____

Relationship with Deceased : _____

Contact Number : _____

Date : _____