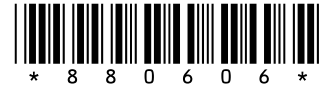

AVIVA

DEATH CLAIM FORM
CLAIMANT'S STATEMENT

AVIVA LTD
Group Life & Health Claims
4 Shenton Way, #01-01 SGX Centre 2
Singapore 068807
Tel: 6827 8030 Fax: (65) 6827 7705
Company Registration No.196900499K

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)

<u>If death is resulted from accidental or violent causes, the following additional documents are required</u>:
(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 Aviva Ltd 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 Aviva Ltd. A photocopy of this authorization shall be considered as effective and valid as the original.

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 Aviva (and Aviva 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), my/our insurance coverage and/or managing my/our relationship with Aviva.

I/We also consent to Aviva (and Aviva related group of companies) transferring my/our personal data to Aviva related group of companies and/or third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.

For full details of the purposes of collection, use and disclosure of your personal data, please visit http://www.aviva.com.sg/pdpa.html.

Signature of Claimant : ____________ Signature of Employer: ____________

Name of Claimant: ____________

NRIC No: ____________ Company's Name & Stamp: ____________

Relationship of Claimant to Deceased: ____________ Date: ____________

Address : ____________ Telephone No: ____________

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DEATH CLAIM FORM
PHYSICIAN'S STATEMENT

AVIVA LTD
Group Life & Health Claims
4 Shenton Way, #01-01 SGX Centre 2
Singapore 068807
Tel: 6827 8030 Fax: (65) 6827 7705
Company Registration No.196900499K

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: ______________________

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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 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).