AIA SINGAPORE
DEATH CLAIM FORM

PART I – CLAIMANT'S STATEMENT (to be completed by the Claimant)

A) POLICY DETAILS

Policy Number(s):

B) PARTICULARS OF DECEASED

Name of Deceased:	Date of Birth (dd/mm/yy):	NRIC No. (If deceased is not a Singapore Citizen, please provide FIN/Passport No.) :

Deceased's last address in Singapore:	Occupation:	Date last at work (dd/mm/yy):

C) PARTICULARS OF CLAIMANT

Name of Claimant:	Contact No.	Relationship to Deceased:	NRIC No. (If claimant is not a Singapore Citizen please provide FIN/Passport No.) :

Claimant's Address:	In what capacity or by what title do you claim this assurance?

D) DETAILS OF DEATH

1. Country and Place of death. Please specify the name of hospital if death occurred in hospital.	
2. What is the date of death?	___________/___________/___________(dd/mm/yy)
3. What is the cause of death?	
4. Was the death due to self-destruction or self-inflicted injuries?	□ Yes □ No
5. Was a coroner's inquest held?	□ Yes □ No If "Yes", please enclose a certified true copy* of the Coroner's Inquiry Report
6. Was an autopsy or post mortem done?	□ Yes □ No If "Yes", please enclose a certified true copy* of the Post Mortem or Toxicology Report

E) OTHER INSURANCE

1. Was the deceased insured with any other companies?

□ Yes □ No If "Yes", please complete the following:

Name of Insurance Company	Date of Issue (dd/mm/yy)	Sum Insured (S$)

PT0007001 (03/2012 06/2014 01/2016)

** Copies of the document(s) may be certified to be true copies by our Officers at AIA Customer Service Centre or a Singapore lawyer. Please note that the original documents have to be produced for certification.*

AIA Singapore Private Limited (Reg. No. 201106386R)
AIA Customer Service Centre, 1 Finlayson Green, Singapore 049246
Monday to Friday: 8.45am – 5.30pm
AIA Customer Care Hotline: 1800 248 8000 AIA.COM.SG

F) PLEASE COMPLETE THIS SECTION IF DEATH WAS DUE TO NATURAL CAUSES (E.G. ILLNESS)

1. Please state the date deceased first complained of or gave other indication of his/her last illness.	_________/________/________ (dd/mm/yy)
2. What symptom(s) did the deceased suffer from for his/her last illness?	
3. Please state the date deceased first consulted a physician for his/her last illness.	_________/________/________ (dd/mm/yy)

	Name & Address of Doctor(s)	Disease/Condition	Date of Consultation
4. Please state the names and addresses of all doctors who attended to the deceased during his/her last illness and 3 years prior to death:			

G) PLEASE COMPLETE THIS SECTION IF DEATH WAS DUE TO AN ACCIDENT OR UNNATURAL CAUSES

	Place & Country of Accident	Date of Accident (dd/mm/yy)	Time of Accident
1. Please state the date, time, place and country where the accident occurred.			
2. Please describe and provide details on how the accident occurred.			

3. Was a police investigation carried out?	☐ Yes ☐ No If "Yes", enclose copy of report and complete the following :	
	Name(s) of Investigation Officer Charge	Police Station (Branch/Address)

H) PLEASE COMPLETE THIS SECTION IF DEATH OCCURRED OVERSEAS

	Date left Singapore	Purpose of Visit Overseas	Intended Length of Visit
1. Please state the date deceased left Singapore, the purpose and intended length of the visit overseas.			

2. Please state the name and address of the doctor who certified the death.	
3. Was the deceased cremated or buried overseas?	☐ Yes ☐ No If "Yes", please provide cremation/burial permit/documentation
4. Letter from ICA (Immigration and Checkpoint) confirming the invalidation of Deceased's Singapore IC/Passport is enclosed	☐ Yes ☐ No

I) TESTAMENT & FAMILY STATUS

1. Did the deceased leave a Will?	☐ Yes ☐ No If "Yes", please enclose a certified true copy* of the Last Will, if available.
2. Was a Grant of Probate or Grant of Letters of Administration applied for?	☐ Yes ☐ No If "Yes", please enclose a certified true copy* of the Grant of Probate / Grant of Letters of Administration, if available.
3. What was the deceased's marital status?	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

FSC/Insurance Representative's Name	FSC/Insurance Representative's Code	RNF Registration No.	Contact No.

Name of Policy Holder / Claimant: NRIC/FIN/Passport No.:

CLAIMANT'S AUTHORISATION & DECLARATION

1. I/We, acknowledge and accept that the furnishing of this form, or of any other forms supplemental thereto, by AIA Singapore Private Limited ("AIA Singapore") is neither an admission that there was any insurance in force on the life in question, nor an admission of liability nor a waiver of any ofits rights or defenses.

2. I/We:
   (a) hereby declare that I/we are duly authorized 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");
   (b) declare that all Information is complete, true and correct and that no information or materials have been withheld and that AIA Singapore will rely and act on the Information accordingly. Otherwise, AIA Singapore shall be at liberty to deny liability or recover amounts paid, whether wholly or partially;
   (c) acknowledge and accept that AIA Singapore 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
   (d) acknowledge and accept that AIA Singapore expressly reserves its rights to require or obtain further information asit deems necessary.

3. I/We hereby authorise, agree and consent to:
   (a) persons and organizations, 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/organizations, my/our or the insured person's employers or financial service providers, or their third party service providers or representatives (collectively "Third Parties") disclosing and releasing to AIA Singapore, its associated persons/organizations, its and their third party service providers and its and their representatives, whether within or outside Singapore (collectively "AIA Persons"), any information concerning the policy owner and the insured person(s) at any time, including all personal data and information, medical information, medical history, consultation history and notes, prescriptions, treatments, descriptions of medical services rendered, and any employment and financial information, including the taking of copies of such records (collectively "Personal Data"), relevant for the Purpose (defined below);
   (b) the AIA Persons sharing the scope of sub-clause
   (c) the AIA Persons, including their approved medical examiners or laboratories, performing any necessary medical assessments and examinations and tests to determine, assess and evaluate the health of the insured person(s);
   (d) the AIA Persons collecting, using, disclosing, storing, retaining and/or processing (collectively, "Using"/"Use") the Personal Data for the Purpose; and
   (e) waive any right (on my own behalf and on behalf of the insured person(s) where applicable, in respect of which I/we represent and warrant that the insured person(s) have granted me/us authority to so waive) to bring a claim of any nature against any of the AIA Persons in respect of any above-mentioned Use and/or any Use of any Personal Data for the Purpose.

Where I/we are not the insured person, I/we represent and warrant that I/we have obtained the consent of the insured person(s), except to the extent such consent is not required under relevant laws: (i) to collect their Personal Data; (ii) to disclose their Personal Data to the AIA Persons; and (iii) for the AIA Persons and Third Parties to Use any of their Personal Data in the manner and for the purposes described in this Clause. I/We hereby agree to indemnify AIA Persons for all losses and damages that AIA Persons may suffer in the event that I/we are in breach of any representation and warranty provided by me/us herein. In this Clause, "**Purpose**" means any of the purposes described in the AIA Personal Data Policy, including but not limited to processing of this form, to provide subsequent advice or services to me/us or the insured person in relation to any existing or future policy/policies/programmes that I/we may hold/participate with AIA Singapore.

4. I/We hereby declare and agree that I am/we are not a "U.S. person" for U.S. federal income tax purposes and that I am/we are not acting for, or on behalf of a U.S. person. I/We understand that AIA Singapore, believing this statement to be true, will rely on it and act on it. In the event this statement is false, AIA Singapore reserves the right and shall be entitled to cancel or terminate this Policy/Policies and pay reasonable compensation to me/us in consideration of such cancellation or termination as may be required under Singapore laws.

   I/We agree to notify AIA Singapore within 30 days of any change in my/our status as a U.S. person for the purposes of U.S. federal income tax. I/We agree to indemnify AIA Singapore in respect of any false or misleading information regarding my/our "U.S. person" status for U.S. federal income tax purposes.

   Note: Please submit W-8BEN/W-8BEN E (whichever is applicable) and satisfactory documentary evidence to us. Documentary evidence includes government identity document (e.g. passport, ID card), tax certificate of residence, certificate of loss of nationality or ACRA equivalent.

   ☐ By ticking the box on the left, I/we, notwithstanding anything contrary in this form, hereby declare and agree that I am/we are a "U.S. person" for U.S. federal income tax purposes. I/We agree to notify AIA Singapore within 30 days of any change in my/our status as a U.S. person for the purposes of U.S. federal income tax. I/We agree to indemnify AIA Singapore in respect of any false or misleading information regarding my/our "U.S. person" status for U.S. federal income tax purposes.

   Note: Please submit W-9 form to us.

5. This authorisation and declaration shall bind my/our successors and assignees, and remains valid, notwithstanding death or incapacity. A photocopy of this authorisation shall be effective and valid as the original.

______________________________ ______________________________

Signature of Claimant **Date (dd/mm/yy)**

PART II - PHYSICIAN'S STATEMENT (to be completed by the Physician at claimant's expense)

A) DECEASED'S PARTICULARS (FROM HOSPITAL/CLINIC'S RECORD)	
Name of Deceased:	NRIC No. (If deceased is not a Singapore Citizen, please provide FIN/Passport No.) :

B) DECEASED'S MEDICAL RECORDS

Question	Response
1. Are you the deceased's usual medical physician?	☐ Yes ☐ No If "Yes", please answer 1a. If "No" please answer 1b.
1a. Please state date of first consultation at your hospital/clinic.	___________/_______________/______________(dd/mm/yy)
1b. Please provide name and address of the deceased's regular doctor.	Name & Address of Regular Doctor

2. Please provide the names and address of any other practitioners who had attended to the deceased during the past 3 years.	Name & Address of Doctor	Consultation Period	Disease/Illness

Question	Response
3. Did you attend to the deceased's last illness?	☐ Yes ☐ No If "Yes", please answer 3a – 3d:
3a. What were the symptoms presented?	
3b. Date symptoms first started	___________/_______________/______________(dd/mm/yy)
3c. What was the diagnosis?	

3d. Please provide treatment administered and the dates.	Treatment Administered	Date of Treatment

4. Have you treated the deceased for any other illness other than the last illness? ☐ Yes ☐ No If "Yes", please provide details:

Disease/Illness	Date of Consultation

5. Were you present when the deceased passed away? ☐ Yes ☐ No If "No", please state the date that you last treated the deceased.

___________/_______________/______________(dd/mm/yy)

Name of Deceased: NRIC/Passport No./FIN No.:

C) DETAILS OF DEATH

1. What was the primary cause of death?	
2. What was the duration between the onset of the condition/illness and death?	
3. Please provide details of any other significant illness(es) that the deceased suffered from and the date of diagnosis.	Disease/Illness | Date of Diagnosis
4. Was there any predisposing cause of the deceased's death in his/her habits (use of alcohol, narcotics, etc), family history, occupation or previous sickness?	☐ Yes ☐ No If "Yes", please provide details:
5. Was the death of the deceased due to suicide, self-destruction or intentional self-inflicted injury?	☐ Yes ☐ No If "Yes", please provide details:
6. Was the cause of death due to an accident?	☐ Yes ☐ No If "Yes", please answer 6a – 6d:
6a. Date & Time of Accident	Date :_______/_______/______(dd/mm/yy) Time:________________a.m./p.m.
6b. Country & Place where the accident occurred.	
6c. Please describe how the accident occurred.	
6d. Please describe the injuries sustained by the deceased assured fully.	
7. Please provide any other information that you feel may be relevant.	

D) PHYSICIAN'S NAME & SIGNATURE

Name of Doctor : ____

Qualification : ____

Signature : ____

Date : ____

Address/Official Stamp: