



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?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
5. Was a coroner's inquest held?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please enclose a certified true copy* of the Coroner's Inquiry Report		
6. Was an autopsy or post mortem done?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please complete the following:		
	Name of Insurance Company	Date of Issue (dd/mm/yy)	Sum Insured (S\$)
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)		
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:	Name & Address of Doctor(s)	Disease/Condition	Date of Consultation

* 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.



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

1. Please state the date, time, place and country where the accident occurred.	Place & Country of Accident	Date of Accident (dd/mm/yy)	Time of Accident
2. Please describe and provide details on how the accident occurred.			
3. Was a police investigation carried out?	<input type="checkbox"/> Yes <input type="checkbox"/> 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

1. Please state the date deceased left Singapore, the purpose and intended length of the visit overseas.	Date left Singapore	Purpose of Visit Overseas	Intended Length of Visit
2. Please state the name and address of the doctor who certified the death.			
3. Was the deceased cremated or buried overseas?	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No		

I) TESTAMENT & FAMILY STATUS

1. Did the deceased leave a Will?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	

J) CLAIMANT'S AUTHORISATION & DECLARATION

- 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") (Reg. No. 201106386R) 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 of its rights or defenses.
- I/We:
 - 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");
 - 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;
 - 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
 - acknowledge and accept that AIA Singapore expressly reserves its rights to require or obtain further information as it deems necessary.
- I/We hereby irrevocably authorise, agree and consent to:
 - Third Parties disclosing and releasing to the Recipients, any relevant information concerning the policyholder and the deceased at any time including all personal and medical information, medical history, consultations, prescriptions, treatment, services rendered and copies of all such information including hospital and medical data, records and reports and in so far as employment and financial information are related to the policy, claim or the assessment of such claim, such employment and financial information as necessary; and
 - any of the Recipients disclosing any such information set out in paragraph 3(a) above to any of the Third Parties or another Recipient at any time; and
 - any of the Recipients using, processing, disclosing or communicating through any means, any information collected or held (whether contained in this form or otherwise) to any Third Parties, for the Purpose;
 - hereby expressly release the Recipients and such other Third Parties to whom information is disclosed from any liabilities and waive any right to bring a claim of any nature against such persons, within or outside Singapore, in respect of such disclosure.
 - For such purposes: (i) "Third Parties" means any persons, organizations, institutions or bodies, within or outside Singapore, including but not limited to, medical sources, hospitals, doctors, other healthcare professionals, laboratories and insurance offices, associated or related parties, independent third parties, regulators, dispute resolution centres. (ii) "Recipients" means AIA Singapore, its or their agents, representatives and subcontractors. (iii) "Purpose" shall mean any matters pertaining to the claim, Policy, and/or any other existing or future policies that the policyholder or insured person may have with AIA Singapore, including but not limited to the provision of advice, information concerning other products, services and/or for any purpose.
- 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.

Date (dd/mm/yy)

Signature of Claimant

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

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

1. Are you the deceased's usual medical physician?	<input type="checkbox"/> Yes <input type="checkbox"/> 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
3. Did you attend to the deceased's last illness?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide details:		
	Disease/Illness		Date of Consultation
5. Were you present when the deceased passed away?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please state the date that you last treated the deceased.		
_____/_____/_____(dd/mm/yy)			



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?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide details:	
5. Was the death of the deceased due to suicide, self-destruction or intentional self-inflicted injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide details:	
6. Was the cause of death due to an accident?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.		

C) PHYSICIAN'S NAME & SIGNATURE

Name of Doctor : _____ Qualification : _____ Signature : _____ Date : _____	Address/Official Stamp: <div style="border: 1px solid black; height: 100px; width: 100%;"></div>
--	--