



AVIVA LTD

4 Shenton Way #01-01, SGX Centre 2, Singapore 068807  
Telephone: 6827 7988 Fax: 6827 7705

**GROUP LIFE & HEALTH CLAIMS  
DEATH CLAIM FORM – CLAIMANT’S STATEMENT**

(Please refer to the instruction overleaf before completing this form)

POLICY NUMBER: \_\_\_\_\_

**SECTION I**

|   |  |                          |                |               |     |
|---|--|--------------------------|----------------|---------------|-----|
| 1) Name of Insured Member   | I.C/Passport/B.C No.   | Occupation               | Marital Status | Date of Birth | Sex |
| 2) Name of Deceased (if other than Insured Member)  | I.C/Passport/B.C No.   | Occupation               | Marital Status | Date of Birth | Sex |
| 3) Relationship of Deceased to Insured Member   | 4) Sum Assured in respect of Deceased  |                          |                |               |     |
| 5) Place of Birth   | 6) Resident at Time of Death   |                          |                |               |     |
| 7) Date of Death  | 9) Place of Death  |                          |                |               |     |
| 9) Cause of Death   | 10) Was the Cause of Death Work-Related:<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |                          |                |               |     |
| 11) If Cause Of Death Is A Result Of Illness, Please State<br>a) Date Illness First Commenced: _____ b) Date First Treated: _____ |  |                          |                |               |     |
| 12) If Cause Of Death Is A Result Of Accident, Please State<br>a) Date of Accident _____ b) Description of Accident: _____        |  |                          |                |               |     |
| 13) Name And Address Of All Physicians Who Attended During His/Her Last Illness/Accident  |  |                          |                |               |     |
| a) Name & Address   |  | b) Date First Attendance |                | c) Illness    |     |
|   |  |                          |                |               |     |
|   |  |                          |                |               |     |

**(NOTE: THIS SECTION IS FOR GROUP POLICYHOLDERS ONLY)**

|   |  |
|---|--|
| 1) Name of Employer/Policyholder  |  |
| 2) If Sum Assured is Based on Salary, Please Furnish a certified True Copy (by employer) of The Insured Member’s Last Pay Slip (for a full month).<br>a) Last Drawn Salary: _____ b) Date of Last Drawn Salary: _____ |  |
| 3) Date of Employment   | 4) Commencement Date of Insurance for Insured Member |
| 5) If deceased is a dependent, effective date of his/her insurance  |  |

**(NOTE: THIS SECTION IS FOR INDIVIDUAL POLICYHOLDER ONLY)**

|   |
|---|
| 1) Has Deceased Left A Will? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2) Who Are The Surviving Family Members Of the Deceased?                              |

In What Capacity Or By What Title Do You Claim The Assurance?  
Is the Deceased insured with other Insurance Company? Yes \_\_\_\_\_ No \_\_\_\_\_  
If Yes (a) Name of Insurance Company: \_\_\_\_\_ (b) Policy No. \_\_\_\_\_

I ..... the undersigned, do solemnly and sincerely declare that the answers given to the above questions are true to the best of my knowledge and belief and that no material fact has been concealed from the Company and I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the Statutory Declaration Act, 1835.

I further hereby consent to AVIVA LTD seeking information from any hospital, physician, person or organisation that may be required regarding the abovenamed deceased.

Signature of Claimant : \_\_\_\_\_  
Name of Claimant : \_\_\_\_\_  
NRIC No. : \_\_\_\_\_  
Address : \_\_\_\_\_  
Company's Stamp (For Group Policy Only) Telephone no. : \_\_\_\_\_

## INSTRUCTIONS

When submitting the claim, please furnish the following documents:

- (1) Certified copy of the DEATH CERTIFICATE
- (2) Certified copy of the BIRTH CERTIFICATE of the deceased
- (3) Original Insurance Policy or Certificate of Insurance
- (4) Certified copy of MARRIAGE CERTIFICATE
- (5) Police Report and/or Coroner's Report if death resulted from accident

NOTE: Any other documents required will be based on case by case basis and we reserve the right to pursue for the said document if they are deemed necessary.

(A) **Claimant's Statement**

- (1) For Group Policy Holder, this statement must be completed and signed by the Authorised Officer.
- (2) For Individual Policy Holder, please note the following:-
  - (a) This form is to be completed by the person to whom the insurance is payable. If there is more than one beneficiary or claimant, a separate form will be furnished by each person.
  - (b) When the policy proceed is payable to the legal representatives of the assured, this statement must be made by his/her executor or administrator together with a certified copy of the relevant Letters of Administration or Grant of Probate.
  - (c) When policy proceed is payable to a named beneficiary of full age, the statement must be made by such beneficiary. When policy proceed is payable to a minor, the statement must be completed by a guardian and an official certificate of whose appointment must be furnished.
  - (d) If a Policy has been assigned, this statement must be completed by the assignee, who must submit the original assignment or a certified copy of it. In the latter case, the original assignment must be surrendered with the Policy when the claim is paid.
  - (e) When policy proceed was payable to a named beneficiary and by the death of the beneficiary has become otherwise payable, a statement duly certified must be furnished, giving the place and date of death of the deceased beneficiary.

(B) **Physician's Statement** must be completed by the Physician who attended the deceased in his last illness or in the event of an accident by the attending Physician. Cost of the Physician's Statement is to be borne by the claimant.



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DEATH CLAIM FORM – PHYSICIAN’S STATEMENT**

**SECTION II – To be completed by Attending Physician**

|  |   |                       |
|--|---|-----------------------|
| 1) Name of Deceased  | I.C./Passport/B.C. No.  | Occupation            |
| 2) Name of Deceased’s Company  | 3) Is The Photograph in the I.C./Passport/B.C that of the deceased?   |                       |
| 4) Date of Death   | 5) Place of Death   |                       |
| 6) What was 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?<br>Yes <input type="checkbox"/> Date symptoms first started: _____<br>Nature of Symptoms: _____<br>No <input type="checkbox"/>   | 9) When did Deceased first consult you for this condition?<br>Date: _____<br>When did Deceased last consult you for this condition?<br>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 <input type="checkbox"/> No <input type="checkbox"/><br>If yes, when was the Deceased first told? |                       |
| 14) Did Deceased suffer from any other illness?  |   |                       |
| Illness  | Period of Illness   | Date of Diagnosis     |
|  |   |                       |
|  |   |                       |
|  |   |                       |
| 15) Was the Death in any way partly attributed to Deceased’s habits, family history, occupation OR previous diseases?<br>If YES, give details.   |   |                       |
| 16) Doctors previously consulted by Deceased for the above condition?  |   |                       |
| <u>Name</u>  | <u>Approximate Date</u>   | <u>Name of Clinic</u> |
|  |   | <u>Address</u>        |
| (1)  |   |                       |
| (2)  |   |                       |
| (3)  |   |                       |
| 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 : _____  |                       |
|  |   |                       |
| _____<br>Clinic or Hospital Stamp  | Postal Address : _____  |                       |
|  |   |                       |