



DEATH CLAIM – CLAIMANT’S STATEMENT

Policy Number(s): <input style="width: 100px; height: 15px;" type="text"/> <input style="width: 100px; height: 15px;" type="text"/> <input style="width: 100px; height: 15px;" type="text"/>
CLAIMS PROCEDURE 1. Please refer to the instruction in page 3 before completing this form. 2. The Claimant will be responsible for the accuracy and integrity of the Information provided. Failure to provide details or disclose all relevant information may delay the claim assessment. 3. The medical reports fees (if any) will be borne by the Claimant. 4. The Company does not admit liability by the mere issue of this or any other form.

1) Name of Assured	Identity/Passport No.	Occupation	Marital Status	Date of Birth	Sex
2) Name of Deceased (if different from Assured)	Identity/Passport/Birth Cert. No.	Occupation	Marital Status	Date of Birth	Sex
3) Relationship of Deceased to Assured	4) Sum Assured in respect of Deceased				
5) Place of Birth	6) Date of Death				
7) Residence at Time of Death	8) Place of Death (specify Hospital if death occurred in Hospital)				
9) Cause of Death	10) Was the Cause of Death Work-Related? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide detail.				
11) If Cause of Death is a result of illness or Suicide, please state a) Date of First Complaint of Illness: c) Date First consulted a Doctor:	b) Details of Symptoms suffered:				
12) If Cause of Death is a result of Accident, please state a) Date and Time of Accident:	b) Description of Accident:				
13) Name and Address of All Doctors who attended (i) during His/Her LAST Illness/Accident, and (ii) His/Her Medical Conditions for the Last 3 Years.					
a) Name of Doctor and Name & Address of Clinic/Hospital	b) Date First and Last Attendance	c) Detail of Illness			



14) If Death occurred overseas, please state:

a) Was the Deceased Buried or Cremated overseas? Yes No
If "Yes", what Documentation was obtained to allow the Burial or Cremation to take place? Please enclose a copy of the Burial / Cremation Permit.

b) Give Names and Addresses of two people, not related to the Deceased / Assignee, who were present at the Burial or Cremation where Death occurred

c) Name of Doctor and Address of Hospital certifying the Death.

15) Was a Post-Mortem or Autopsy carried out? Yes No If "Yes", please submit a copy of the report.

16) Did the Deceased leave A Will? Yes No If "Yes", please provide a certified copy of the Last Will.

17) Who are the Surviving Family Members of the Deceased?

18) In what Capacity or by what Title do you claim the Assurance? Please Indicate your relationship.

Next of Kin Assignee Others

19) Is the Deceased Insured with other Insurer(s)? Yes No If "Yes", please provide

<u>Name of Insurer/ other source</u>	<u>Type of Plan</u>	<u>Date of Issue</u>	<u>Sum Assured</u>
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Declaration and Authorisation

I, (Identity/PP No.) declare that the answers given by me in this Form are in every respect true and correct and that no material information has been withheld nor any relevant circumstances omitted. I do solemnly and sincerely declare that the answers given to the above questions are true to the best of my knowledge.
I further consent to National General Insurance Co. (P.J.S.C.) seeking information from any clinic, hospital, physician, person, organisation, employer that may be required in connection with this claim and I authorise the giving of such information to National General Insurance Co. (P.J.S.C.) A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Witness _____	Signature of Claimant _____
Name of Witness: _____	Name of Claimant: _____
Passport / Identity No.: _____	Passport / Identity No.: _____
Address: _____	Address/Company's Stamp: _____
Telephone no.: _____	Telephone no.: _____
Date: _____	Date: _____



INSTRUCTIONS

When submitting the claim, please furnish the following documents (where applicable):

- 1) Certified true copy of the Death Certificate
- 2) Certified true copy of the Identification (Identity Card, Passport, etc) of the Deceased
- 3) Original Insurance Policy or Certificate of Insurance
- 4) Original Deed of Assignment
- 5) Certified true copy of the Deceased's Marriage Certificate
- 6) Certified true copy of the Birth Certificate of the Claimants
- 7) Certified true copy of the Identification (Identity Card, Passport, etc) of the Claimants

Together with

- 1) Completed Claimant's Statement
- 2) Completed Clinical Abstract Application form
- 3) Any other documents that support the claim, if applicable
- 4) Completed Physician's Statement, if applicable

If death is resulted from accidental or violent causes, the following additional documents are required:

- 1) Certified true copy of the Police Investigation Report
- 2) Post Mortem Report
- 3) Coroner's Inquest Report

NOTES:

1. Please note that the documents and its English translation must be certified by a Notary Public.
2. 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-NGI and shall be furnished at the expense of the claimant(s).
3. The cost of the Physician's Statement and/or medical evidence shall be borne by the claimant.



CLINICAL ABSTRACT APPLICATION
(for Death claim)

To whom It may concern:

Dear Sir/Madam

Please furnish National General Insurance Co. *P.J.S.C.* with a detailed medical report on:

_____ Identity / Passport No.: _____
(Name of Patient)

This report is required for insurance purposes. Upon receipt of this application from National General Insurance Co. *P.J.S.C.* you may furnish a detailed medical report (together with histology report, laboratory results, etc.) whether for use in connection with litigation or for other legitimate purposes.

I agree that a copy of this authorisation form shall be considered as effective and valid as the original.

Signature of Next-Of-Kin

Name: _____

Address: _____

Passport / Identity No.: _____

Date: _____

Relationship to Patient / Deceased: _____