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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

MINDEF & MHA GROUP INSURANCE
DEATH CLAIM FORM

IMPORTANT:
1. Please refer to the **Claims Procedure at a Glance** for documents required for submission of this claim.
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. Aviva Ltd does not admit liability by the mere issue of this or any other form.

SECTION 1 – To be completed by the Claimant

A. Details of Deceased and Insured Member/Insured Affiliate Member

Name of Insured Member/ Insured Affiliate Member (if different from Deceased)		Insured Member's/Insured Affiliate Member's NRIC/FIN/Passport No.		
Name of Deceased	NRIC/FIN/Passport/BC No.	Date of Birth	Marital Status	Gender
Date of Death	Cause of Death	Was the death due to suicide? ❒ Yes ❒ No		
Mailing Address at Time of Death		Place of Death		
Was a post mortem or autopsy carried out? ❒ Yes ❒ No (If "Yes", please submit a copy of the report)		Was any Coroner's Inquest held? ❒ Yes ❒ No		
Did the Deceased leave a will? ❒ Yes ❒ No (If "Yes", please enclose the Last Will)		Who are the surviving family members of the Deceased?		

Is the Deceased insured with other insurance companies? ❒ Yes ❒ No

If "Yes", please indicate:

(1) Name of insurance companies: _____

(2) Policies No. _____

If cause of death is due to **natural event (e.g: illnesses)**, please state:

(1) Date symptoms first presented (dd/mm/yyyy): _____

(2) Date of first consultation with doctor (dd/mm/yyyy): _____

(3) Names and addresses of all doctors / hospitals / clinics who attended to deceased for this illness.

Name(s) of Doctor(s)	Name of Hospital(s) / Clinic(s)

(4) What symptoms did the deceased suffered from before consultation with the above doctor / clinic / hospitals?

_____

_____

SINGAPORE LIFE LTD.
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If cause of death is due to **accidental event (e.g. road traffic accident)**, please state:

(1) Date of accident (dd/mm/yyyy): _____

(2) Place of accident (dd/mm/yyyy): _____

(3) Time of accident: _____

(4) Detailed description of accident:

_____

_____

(1) Detailed description of injuries:

_____

_____

B. CLAIMANT'S DECLARATION AND AUTHORISATION

I/We, hereby declare that the answers given by me/us in this Form are in every respect true and correct and that no material information has been withheld nor any relevant circumstances omitted.

I/We declared that I/We am/are not an undischarged bankrupt. There are currently no actual or pending bankruptcy proceedings against me/us and I/We have not assigned the Policy to any other party.

I/We hereby authorise Singapore Life Ltd. ("Singlife") to request from any hospital, physician, person or organisation, 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 authorise the prior mentioned organisations to disclose all such information to Singlife. A photocopy of this authorisation 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 declare and undertake that I/we have submitted the actual bills and receipts (including electronic/digital copies) issued by the medical institution.

I/We understand that Singlife has the right to:

- Ask for originals/certified true copies of the bills and receipts, or contact the medical institution directly, to confirm that the bills and receipts are original.
- Reject claims, recover amounts paid or impose additional charges, if the claim is false or where there are multiple claims made.

I/We consent to Singapore Life Ltd. ("Singlife") (and Singlife 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) and/or managing my/our relationship with Singlife.

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

I/We have read and understood Singlife's Data Protection Policy which may be found at http://www.singlife.com/pdpa. Singlife's Data Protection Policy may be updated from time to time without notice. I/We am/are aware that I/we should visit your website regularly to ensure that I/we am/are well informed of the updates.

Note: If you are filling up this form on behalf of another person or whereby you are disclosing personal data to us other than yours, you are required to inform such person(s) of the purpose and obtain his/her consent before submitting this form to us. Once you have submitted, you will be deemed to have obtained the necessary consent for us.

Signature of Claimant:.....

Name of Claimant:.....

Relationship with Deceased:.....

NRIC/FIN No:.....

Address:.....

.....

Contact No:.....

Email:.....

Date:.....

Signature of Witness:.....

Name of Witness:.....

NRIC/FIN No:.....

Address:.....

.....

Date:.....