



**DEATH CLAIM FORM  
 CLAIMANT'S STATEMENT**

**For Group Policy Holder, please furnish the following documents:**

- (1) Claimant's Statement (to be completed and signed by the Authorised Officer of the Company)
- (2) Physician's Statement (to be completed by the attending Physician who attended the deceased in his last illness or accident. Cost of the Physician's Statement is to be borne by the Claimant.)
- (3) Certified true copy of the Death Certificate
- (4) Certified true copy of the NRIC/passport of the deceased
- (5) Certified true copy of Marriage Certificate(if the deceased is the spouse of the employee) or Birth Certificate (if the deceased is the child of the employee)

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

- (1) Police Investigation Report
- (2) Coroner's Inquest
- (3) Post Mortem / Autopsy Report
- (4) Toxicological Report

**SECTION I – To be completed by the Company and Claimant**

Name of Company : \_\_\_\_\_ Policy No : \_\_\_\_\_

To Be Completed By Claimant					
1) Name of Employee	NRIC/Passport/BC No	Occupation	Marital Status	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F
2) Name of Deceased (if other than Employee)	NRIC/Passport/BC No	Occupation	Marital Status	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F
3) Relationship of Deceased to Employee	4) Place of Birth of Deceased				
5) Resident at Time of Death	6) Place of Death				
7) Date of Death	8) Cause of Death	9) Was the cause of death work related? <input type="checkbox"/> Yes <input type="checkbox"/> No			
10) If Cause of Death is A Result of Illness, Please State a) Date Illness FIRST Commenced: _____ b) Date First Treated: _____					
11) If Cause of Death is A Result of Accident, Please state a) Date of Accident: _____ b) Description of Accident: _____					
12) Was a Post Mortem or Autopsy carried out? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Please submit a certified true copy of the report					
13) Name & Address of All Physicians Who Attended During His / Her Last Illness / Injury					
a) Name & Address		b) Date First Attended		c) Illness	

To Be Completed By The Company	
1) Sum Assured in respect of Deceased	2) Plan
3) If Sum Assured is Based on Salary, Please Furnish a certified True Copy (by employer) of The Insured Member's Last Pay Slip (for last 3 months). a) Last Drawn Salary: _____ b) Date of Last Drawn Salary: _____	
4) Date of Employment	5) Commencement Date of Insurance for Insured Member
6) If deceased is a dependant, effective date of his / her insurance	

This part must be signed by the patient's parent / legal guardian if patient is below 21 years old.  
 I/We hereby authorize Singlife Ltd. ("Singlife") to request from any hospital, physician, person or organization, 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 authorize the prior mentioned organizations to disclose all such information to Singlife. A photocopy of this authorization shall be considered as effective and valid as the original.  
 I/We declare and undertake that I/we have submitted the actual bills and receipts (including electronic/digital copies) issued by the medical institutions.  
 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 claims is false or where there are multiple claims made.

I/We declare that the statements and answers stated are true and complete to the best of my/our knowledge and belief.  
 I/We consent to Singlife 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 [www.singlife.com/pdpa](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.

Signature of Claimant : \_\_\_\_\_ Signature of Employer: \_\_\_\_\_

Name of Claimant: \_\_\_\_\_ Company's Name & Stamp: \_\_\_\_\_

NRIC No: \_\_\_\_\_ Relationship of Claimant to Deceased: \_\_\_\_\_ Date: \_\_\_\_\_

Address : \_\_\_\_\_ Telephone No: \_\_\_\_\_



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**SECTION II – To be completed by Attending Physician. The medical report fee, if any, will be borne by the Claimant.**

1) Name of Deceased	NRIC/Passport/BC No	Occupation																
2) Name of Deceased's Company	3) Is The Photograph in the NRIC / Passport that of the deceased?																	
4) Date of Death	5) Place of Death																	
6) What is 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? <input type="checkbox"/> Yes Date symptoms first started: _____  <input type="checkbox"/> No	9) When did Deceased first consult you for this condition? Date: _____ When did Deceased last consulted you for this condition? 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when was the Deceased first told?																	
14) Did Deceased suffer from any other illness?																		
<table border="1" style="width:100%; border-collapse: collapse;"><thead><tr><th style="width:30%;">Illness</th><th style="width:20%;">Period of Illness</th><th style="width:20%;">Date of Diagnosis</th><th style="width:30%;">Date &amp; Type of Treatment</th></tr></thead><tbody><tr><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td></tr></tbody></table>	Illness	Period of Illness	Date of Diagnosis	Date & Type of Treatment														
Illness	Period of Illness	Date of Diagnosis	Date & Type of Treatment															
15) Had the illness / injury prevented the Deceased from working? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please indicate the medical leave / hospitalisation leave period the Deceased was away from work:																		
16) Was the Death in any way partly attributed to Deceased's habits, family history, occupation or previous diseases? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide details:																		
17) Doctors previously consulted by Deceased for the above condition?																		
<table border="1" style="width:100%; border-collapse: collapse;"><thead><tr><th style="width:30%;">Name</th><th style="width:20%;">Approximate Date</th><th style="width:30%;">Name of Clinic</th><th style="width:20%;">Address</th></tr></thead><tbody><tr><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td></tr></tbody></table>	Name	Approximate Date	Name of Clinic	Address														
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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: _____																	
	Postal Address: _____																	
_____																		
Clinic or Hospital Stamp																		

**IMPORTANT NOTE: 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 Singapore Life Ltd. and shall be furnished at the expense of the Claimant(s). The cost of the Physician's Statement and/or medical evidence shall be borne by the Claimant(s).**