GROUP DEATH CLAIM FORM

Dear employer,

We are sorry to learn about the death of your employee.

In order for us to process your claim, we require the following:

(1) Group Death Claim Form
(2) Consent for Medical Report (by deceased's next of kin)
(3) Certified true copy of death certificate (by employer)
(4) Last drawn salary slip
(5) Newspaper clipping (if any) and police report (if death was a result of accident)

Once we received **ALL** the above required documents, we will process your claim and inform you of the outcome as soon as possible.

NOTE:
Please note that we may also require your submission of the following documents, if it deems necessary, for our assessment of the claim:

(1) Medical Report
(2) Coroner's Report

GROUP DEATH CLAIM FORM

IMPORTANT NOTES :

(1) The issue of this claim form is not an admission of liability.
(2) This claim form is to be completed by the **employer**.
(3) Tokio Marine Life Insurance Singapore Ltd. ("TMLS") reserves the right to request for additional medical reports when it deems necessary.

PART 1 : DETAILS OF EMPLOYER & EMPLOYEE

Name of employer : _____

Subsidiary / cost centre : _____ Group policy no: _____

Name of employee : _____ Benefit plan : _____

NRIC / Passport No. : _____ Marital status : _____ Sum assured : _____

Date of birth (dd/mm/yyyy) : _____ Date of employment : _____ Gender : ☐ Male ☐ Female

Designation : _____

PART 2 : DETAILS OF DEATH

2.1 Date of death (dd/mm/yyyy) : _____ Place of death _____

2.2 Residence address at time of death : _____

2.3 Cause of death : _____

2.4 Was the cause of death due to : ☐ Job related? ☐ Illness? ☐ Accident?

PART 3 : OTHER INFORMATION

3.1 Name and address of physician(s) who attended to the deceased during his / her last illness / accident :

_____

3.2 Name and address of physician(s) who attended to the deceased at time of death:

_____

Declaration

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

Personal Data Notice

We represent to, warrant and undertake with TMLS that collective consents have been obtained from each of the employees and their respective life assureds and dependants allowing TMLS to collect, use, process and disclose the personal data in accordance with the terms and conditions as stated in the insurance application form or TMLS's Data Protection Policy available at www.tokiomarine.com, which we / they have read, understood and agreed to the same

_____ _____

Authorised Signature & Date (dd//mm/yyyy) Company Stamp

Name : _____ NRIC / Passport No : _____

Designation: _____ Email : _____ Contact No: _____

Tokio Marine Life Insurance Singapore Ltd. (Company Reg. No.: 194800055D)
20 McCallum Street, #07-01 Tokio Marine Centre, Singapore 069046 T: (65) 6592 6100 F: (65) 6223 9120 W: tokiomarine.com

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GROUP DEATH CLAIM
MEDICAL REPORT FORM

1. Name of deceased : _____
(as stated in NRIC / Passport)

2. NRIC / Passport No. : _____

3. Date of death : _____ Time of death : _____
(dd/mm/yyyy)

Place of death : _____

4. **DETAILS OF CONSULTATION / TREATMENT**

(a) Diagnosis : _____

(b) Date of deceased's first consultation with you : _____
(dd/mm/yyyy)

(c) Please state symptoms presented and date symptoms first appeared in the box provided below :

Symptoms presented at first consultation	Date symptoms first started (dd/mm/yyyy)

(d) Date of diagnosis : _____
(dd/mm/yyyy)

(e) Diagnosis was first made by (name of doctor) : _____

(f) Date when diagnosis was first made known to the deceased : _____
(dd/mm/yyyy)

(g) Date when the deceased first became aware of symptoms : _____
(dd/mm/yyyy)

(h) In your opinion, how long do you think the illness / condition has existed prior to the first consultation with you?

_____

_____

(i) How long had the deceased suffered from the illness? _____
(dd/mm/yyyy)

(j) Date when treatment first given to the deceased : _____
(dd/mm/yyyy)

5. Was there any predisposing cause of the deceased's death, in his / her habits (use of alcohol, narcotics, etc), family history or occupation? ☐ Yes ☐ No

If **yes**, please provide full details including the date of diagnosis and source of information :

_____

_____ _____

Hospital / Clinic Stamp

Signature of Attending Doctor

Date (dd//mm/yyyy) _____

Name and Address

Qualification

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6. Did the deceased suffer from any other illness / injuries? ☐ Yes ☐ No
If **yes**, kindly provide the details below :

Illness / Injuries	Date first started

7.

Cause of death		Approximate Interval between onset and death			
		Years	Months	Days	Hours
(a)	due to (or as a consequence of)				
(b)	due to (or as a consequence of)				

8. Are you the deceased's regular doctor? ☐ Yes ☐ No
If **Yes**, since when : _____ (dd/mm/yyyy)
If no, kindly provide the name and address of his / her usual physician, if known to you :
Name of doctor / specialist :

Address of clinic :

9. Was the patient being referred to you? ☐ Yes ☐ No
If **Yes**, please provide:
(a) Date of referral : _____ (dd/mm/yyyy)
(b) Name and address of the referring doctor :

10. Kindly provide us with additional information, if any, to further assist us in assessing this claim :

Hospital / Clinic Stamp

Date (dd//mm/yyyy) _____

Signature of Attending Doctor

Name and Address

Qualification

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CONSENT FORM FOR MEDICAL REPORT

NAME OF PATIENT : _____

NRIC NO. : _____ GROUP POLICY NO. : _____

This consent form is required for an insurance claim.

I / We hereby authorize:

(a) any medical source, insurance office, or organization to release to or when requested to do so by Tokio Marine Life Insurance Singapore Ltd. ("TMLS"), any relevant information concerning the above-named patient, and;

(b) TMLS to release to any medical source, insurance office, or organization, any relevant information concerning the above-named patient, at any time.

A photocopy of this authorization shall have the same effect as the original.

Yours faithfully

_____

Signature of *Patient / Patient's Parent / Next-Of-Kin

Name : _____

Address : _____

_____

NRIC No. : _____ Relationship to Patient : _____

* Delete accordingly

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