



# Accompanying Report of Death Claim

Name of diseased (Insured) ..... Gender..... Age .....

Address .....

Policy no. 1. .... 2. .... 3. ....

1. Did you know the insured personally or in what kind of relationship?	1. ....
2. How long did you know the insured?	2. ....
3. When did you receive death notification?	3. ....
4. Date of death	4. ....
5. Place of death	5. ....
6. Cause of death	6. ....
7. Duration of last illness/injury	7. ....
8. Which neighbors did you inquire about the death of the insured? (Please specify name-address.)	8. .... .....
9. What are the details from the inquiries?	9. .... .....
10. What was the occupation of the insured at the time of death? Please specify occupation details and workplace.	10. .... ..... .....
11. Was the insured treated at any medical facility or by any physician before and at the time of death?	11. .... .....
12. Did you find the body after death? (Please specify the date if the body was found.)	12. .... .....
13. Did you attend the funeral of the insured?	13. ....
14. Did the insured have life insurance/insurance with other companies? Total sum assured.	14. .... .....
15. Other details.	15. ....

I hereby certify that the above statements are true and correct in every aspect.

Reported by.....

(.....)

Position.....

Telephone.....

Date.....

# Document Checklist for Death and Critical Illness Claim



Name of insured ..... Policy no. ....  
 Company..... Insurance certification no. ....  
 Submitted by..... Date.....Telephone.....

	Submitted	Not submitted
<b><u>In case of natural death (from illness)</u></b>		
1. A photocopy of the death certificate certified true copy by the beneficiary	<input type="checkbox"/>	<input type="checkbox"/>
2. A photocopy of the insured's house registration with indication of "death" certified true copy by the beneficiary	<input type="checkbox"/>	<input type="checkbox"/>
3. A photocopy of the insured's ID card certified true copy by the beneficiary	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>Documents proving the identity of the beneficiary (according to the Anti-Money Laundering Act B.E. 2542)***</u></b>		
4. A photocopy of the beneficiary's house registration certified true copy by the beneficiary	<input type="checkbox"/>	<input type="checkbox"/>
5. A photocopy of the ID card of every beneficiary certified true copy by the beneficiary	<input type="checkbox"/>	<input type="checkbox"/>
6. A copy of the beneficiary's photo with full-face view along with clear ID card certified true copy by the beneficiary (1 person/1 copy and a color copy only)	<input type="checkbox"/>	<input type="checkbox"/>
7. A photocopy of the beneficiary's birth certificate certified true copy by a legal guardian in case of the beneficiary being a minor	<input type="checkbox"/>	<input type="checkbox"/>
8. Death Claim Application Form (Form no. 1) signed by the beneficiary (1 person/1 form)	<input type="checkbox"/>	<input type="checkbox"/>
9. Medical Report Form (Form no. 2) only in the case of death at the hospital (or document as in item 20)	<input type="checkbox"/>	<input type="checkbox"/>
10. Accompanying Report of Death Claim (Form no. 3) by the Human Resources Department	<input type="checkbox"/>	<input type="checkbox"/>
11. A photocopy of the job application, employment contract, record of attendance time, and evidence of receiving or paying salary for the past 3 months, certified true copy by the Human Resources Department	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>In case of unnatural death (from accident or murder), submit additional documents as follows</u></b>		
12. A photocopy of the daily police report certified true copy by a police officer	<input type="checkbox"/>	<input type="checkbox"/>
13. A photocopy of the autopsy report or	<input type="checkbox"/>	<input type="checkbox"/>
14. A photocopy of the investigation report on the body, in the event of an autopsy, certified true copy by a police officer or a coroner	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>In case of death from critical illness, submit additional documents as follows</u></b>		
15. Critical Illness Claim Application Form	<input type="checkbox"/>	<input type="checkbox"/>
16. A photocopy of medical history from the onset of illness to date (OPD card) from all hospitals receiving treatment	<input type="checkbox"/>	<input type="checkbox"/>
17. A photocopy of biopsy result indicating critical illness (pathology), copies of special examination results e.g. X-ray film, CT, MRI	<input type="checkbox"/>	<input type="checkbox"/>
<b>Note:</b>		
1. In case the beneficiary is the company/policyholder, a committee member with the authority to act on behalf of the company or an authorized person <b>shall</b> sign the Death Claim Application Form (Form no. 1) along with attaching the document as in item 5.		
2. In case the beneficiary is a minor, Form no. 1 along with documents as in item 4, 5, 6 are signed by the beneficiary and a legal guardian.		
***The Anti-Money Laundering Act B.E. 2542 (AMLO) requires life insurance companies to perform customer identity verification (KYC), effective from 26 September 2021 onward.		
<b><u>Other important documents to be submitted depending on the case</u></b>		
18. A photocopy of the evidence of the insured's or the beneficiary's name/surname change, if it does not match with that on the policy, certified true copy by the beneficiary.	<input type="checkbox"/>	<input type="checkbox"/>
19. A photocopy of the insured's or the beneficiary's marriage certificate certified true copy by the beneficiary.	<input type="checkbox"/>	<input type="checkbox"/>
20. A photocopy of the death certificate certified true copy by an officer	<input type="checkbox"/>	<input type="checkbox"/>
21. Accident photos or news from newspaper (if any)	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>This section is for Company officer only</u></b>		
The Company has received and examined the above documents. It appears that the documents are		
<input type="checkbox"/> Complete		
<input type="checkbox"/> Incomplete. The missing documents are .....		
Group Insurance Claim Division .....	Date .....	



Death Claim Application Form (Claimant's Statement) Form No. 1

Warning: Any fraudulent claim or false evidence or any activity supported to the fraud would be imprisoned for maximum 3 years or fine for 300,000 Baht or both according to Section 114/4 of the Life Insurance Act 2019.

Name-surname of diseased .....Gender.....Age.....years
Policy no. (Please specify every policy.)
1) Policy no. .... Amount of sum assured.....THB
2) Policy no. .... Amount of sum assured.....THB

1. Current address No. .... Street..... Sub-district.....District .....Province .....
2. Occupation before death ..... Job description .....
3. Date of death ..... Place of death .....
Cause of death .....
4. Names and addresses of all physicians treating the deceased during the last illness and during the previous 3 years.

Table with 4 columns: Name-surname of attending physician, Hospital/Clinic, Treatment date, Disease or illness

5. The deceased has life insurance or insurance with any company. (Please provide details)
Company Policy no. Contract date Amount of sum assured

Personal Data Protection Statement:
The Company will process the personal data you provided or will provide to carry out the purposes for which you have specified or requested, and you give consent to the Company to collect, use, and disclose your health information and/or medical history or other sensitive personal data to other persons or entities, including the OIC, as necessary based on the specified purposes. You can find details of the Company processing guidelines in the Privacy Policy https://www.tokiomarine.com/th/en-life/global/privacy-policy.html or scan QR code.



The undersigned of this form claims Tokio Marine Life Insurance (Thailand) PCL. and acknowledges that the memorandum and evidences from all physicians providing medical treatment to the deceased, including other documents used in this application form are to be regarded as a part of this death claim. Moreover, the undersigned agrees that this application form or any other printed form provided by the Company does not constitute the Company's assurance that the above life insurance policy is still in effect nor does it constitute a waiver of any of the Company's defenses.

Signature of claimant.....(Policy beneficiary)
(.....)

Address of claimant..... Telephone.....
Write at ..... Date.....

To prevent delay, please sign the consent letter at the end of this form.

Letter of Consent and Authorization

I hereby give consent to the physicians, hospitals, clinics, life insurance companies; or organizations, medical facilities; or any other person that have treated, kept records or known the health history or other details pertaining to the deceased to have the power to report the illnesses, injuries, medical history, prescriptions, counseling or treatments, and copies of hospital records and the deceased's medical records, including other information to Tokio Marine Life Insurance (Thailand) PCL. or the Company's representative. A photocopy of this consent letter is regarded as equally effective as the original.

Signature of consenter..... Telephone.....
(.....)

Relationship with the deceased..... Date.....



# Document Checklist for Death Claim

Name of insured ..... Policy no. ....  
 Company..... Insurance certification no. ....  
 Submitted by..... Date.....Telephone.....

	Submitted	Not submitted
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2. A copy of the insured's house registration with indication of "death" certified true copy by the beneficiary	<input type="checkbox"/>	<input type="checkbox"/>
3. A copy of the insured's ID card certified true copy by the beneficiary	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>Documents proving the identity of the beneficiary (according to the Anti-Money Laundering Act B.E. 2542)***</u></b>		
4. A copy of the beneficiary's house registration certified true copy by the beneficiary	<input type="checkbox"/>	<input type="checkbox"/>
5. A copy of the ID card of every beneficiary certified true copy by the beneficiary	<input type="checkbox"/>	<input type="checkbox"/>
6. A copy of the beneficiary's photo with full-face view along with clear ID card certified true copy by the beneficiary (1 person/1 copy and a color copy only)	<input type="checkbox"/>	<input type="checkbox"/>
7. A copy of the beneficiary's birth certificate certified true copy by a legal guardian in case of the beneficiary being a minor	<input type="checkbox"/>	<input type="checkbox"/>
8. Death Claim Application Form (Form no. 1) signed by the beneficiary (1 person/ 1 form)	<input type="checkbox"/>	<input type="checkbox"/>
9. Medical Report Form (Form no. 2) only in the case of death at the hospital (or document as in item 17) or front and back of death notice in the case of death at home or a medical certificate before death	<input type="checkbox"/>	<input type="checkbox"/>
10. Accompanying Report of Death Claim (Form no. 3) by the Human Resources Department	<input type="checkbox"/>	<input type="checkbox"/>
11. A copy of the job application, employment contract, record of attendance time, and evidence of receiving or paying salary for the past 3 months, certified true copy by the Human Resources Department	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>In case of unnatural death (from accident or murder), submit additional documents as follows</u></b>		
12. A copy of the daily police report certified true copy by a police	<input type="checkbox"/>	<input type="checkbox"/>
13. A copy of the autopsy report or	<input type="checkbox"/>	<input type="checkbox"/>
14. A copy of the investigation report on the body, in the event of an autopsy, certified true copy by a police or a coroner	<input type="checkbox"/>	<input type="checkbox"/>
<b>Note:</b>		
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16. A copy of the insured's or the beneficiary's marriage certificate certified true copy by the beneficiary.	<input type="checkbox"/>	<input type="checkbox"/>
17. A copy of the death certificate certified true copy by an officer	<input type="checkbox"/>	<input type="checkbox"/>
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<b><u>This section is for Company officer only</u></b>		
The Company has received and examined the above documents. It appears that the documents are		
<input type="checkbox"/> Complete		
<input type="checkbox"/> Incomplete. The missing documents are .....		
Group Insurance Claim Division ..... Date .....		



# แบบฟอร์มรายงานแพทย์ (Physician's Statement)

TOKIOMARINE

เอกสารหมายเลข 2

1. ชื่อผู้เสียชีวิต (Deceased's Name in full)..... เพศ (Sex)..... อายุ (Age).....ปี  
น้ำหนัก (Weight).....กิโลกรัม (Kilograms) ส่วนสูง (Height).....เซนติเมตร (Centimeters) H.N..... A.N.....  
ที่อยู่ (Address).....  
..... อาชีพ (Occupation).....

2. ท่านรู้จักผู้เสียชีวิตมานานเท่าใด/ How long had you known the deceased?.....

3. ก. ท่านเป็นแพทย์ผู้รักษาหรือที่ปรึกษาผู้เสียชีวิตมาตั้งแต่เมื่อใด ด้วยโรคใด / When had you been the medical attendant or adviser of deceased?  
And from what disease?.....  
ข. การเจ็บป่วยที่เป็นเหตุให้เสียชีวิตครั้งนี้ ผู้เสียชีวิตได้รับการรักษาจากแพทย์ท่านอื่นมาก่อนหรือไม่ ถ้ามี โปรดระบุ / Did the deceased receive any treatment before death? If yes, please specify the doctor's name. ....

4. ก. ท่านเป็นแพทย์ผู้รักษาการเจ็บป่วยครั้งสุดท้ายของผู้เสียชีวิตหรือไม่ / Did you attend deceased during his last illness?  Yes  No  
ข. ถ้าใช่ ผู้เสียชีวิตป่วยเป็นโรคอะไร / If so, for what disease? .....  
ค. วันแรกที่ท่านเยี่ยมผู้เสียชีวิต / Date of your first visit? .....  
ง. วันสุดท้ายที่ท่านเยี่ยมผู้เสียชีวิต / Date of your last visit? .....

5. ก. สถานที่ที่เสียชีวิต / Place of Death .....  
ข. วันที่เสียชีวิต / Date of Death ..... ค.เวลาที่เสียชีวิต / Time of Death .....

6. ก. สาเหตุโดยตรงที่ทำให้เสียชีวิตคือ / What was the immediate cause of death?  
.....  
.....  
ข. โรค / อาการเจ็บป่วยที่ทำให้เสียชีวิตเป็นมานานเท่าใด / How long did deceased suffer from this disease?  
.....  
ค. ตามความเห็นของท่านโรค/ อาการเจ็บป่วยที่ทำให้เสียชีวิตเป็นมานานเท่าใด / In your opinion, how long did the deceased suffer from this disease?  
.....

7. ผู้เสียชีวิตป่วยเป็นโรคอื่นที่สำคัญอะไรบ้างหรือไม่ เมื่อใด / From what other important disease, if any, did the deceased suffer?  
.....

8. ผู้เสียชีวิตได้ใช้สุราหรือยาเสพติดหรือไม่/ถ้ามี วัตถุนั้นเป็นเหตุให้เสียชีวิตหรือไม่ / Did deceased use alcohol or narcotics?/If so, did they contribute to the fatal disease?  
.....

9. ผู้เสียชีวิตได้รับการตรวจระดับแอลกอฮอล์ในเลือดหรือไม่ / Test for Alcohol level? If yes, what is the result?  
 Not done  Done: Result.....

10. ผู้เสียชีวิตมีการตรวจหาเลือดโรคเอดส์หรือไม่ / Test for HIV? If yes, what is the result?  
 Not done  Done: Result.....

11. การเสียชีวิตครั้งนี้มีการผ่าพิสูจน์ศพ/ชันสูตรพลิกศพหรือไม่ ถ้ามี โปรดระบุ / Is there the autopsy? If yes, please state  
 No  Yes.....

เขียนที่: Sign at..... วันที่: Date.....  
อำเภอ: District..... จังหวัด: Country of .....  
ลงชื่อ: Signature..... คุณวุฒิ: Qualification .....  
ชื่อและที่อยู่ (โปรดเขียนตัวบรรจง) : Name address (Please print).....  
.....  
.....