DEATH CLAIM FORM (GROUP CLAIM)

SECTION A

Section A of this form is to be completed by the claimant who is legally entitled to policy money. Every question must be fully answered. The Company reserves the right to require further information should it deem necessary. Submission of this Claim Form does not guarantee admission of liability.

Policy No : _____

Broker/Account Manager's name: _____ Broker/ Account Manager's Contact No. : _____

Instruction – Supporting documents required

- ☐ Death claim form
- ☐ Death Statement of Medical Examiner
- ☐ Certified copy of Deceased and Claimant's IC
- ☐ Certified copy of Death Certificate
- ☐ Certified copy of Burial Certificate
- ☐ Original certificate (if any)
- ☐ Certified copy of proof of relationship between claimant and deceased
- ☐ Certified copy of Sijil Faraid / Letter of Administration (if applicable)

Additional requirements on accidental death

- ☐ Detailed Post Mortem report
- ☐ Certified copy of Toxicology report, if any
- ☐ Certified copy of police report
- ☐ Newspaper Cutting, if any

Additional requirements for death in overseas

- ☐ Confirmation letter from National Registration Department (JPN)
- ☐ All relevant documents issued by Foreign Authority must be certified by Malaysia Embassy or Public Notary

DETAILS OF DECEASED

Name of Deceased in full _____

New IC No _____ Old IC No. _____ Age _____

Last Address of Deceased _____

_____

Name of the Employer of Deceased at the time of death _____

Address of the Employer _____

_____

Date of Employment _____ (dd/mm/yyyy) Office Phone No. _____

What family has the Deceased left? ☐ Spouse ☐ No.of Child _____ ☐ Parent ☐ Others, please specify _____

DETAILS OF CLAIMANT

Name of Claimant _____

New IC No _____ Old IC No. _____ Age _____

Correspondence Address _____

_____

_____ _____

Mobile Phone No. _____ E-mail address _____

Phone No. _____ Fax No. _____

What is your relationship with the Deceased ? _____

Please state bank account details in order for us to credit the payment directly into Claimant's bank account.

Bank : _____ **Bank Branch :** _____

Bank Account Holder Name : _____ **Bank Account no.:** _____

Company Registration no : _____ **(Eg:266243D)**

The Payment which has been made based on the account details provided by you will be deemed as full payment and we shall be discharged from any existing and future claim and demand in relation to it.

1 Date of death _____ (dd/mm/yyyy) Time _____ (am/pm)

2 Cause of death _____

3 Place of death _____

4 When did Deceased **first** complain of or give indication of his / her last illness ? _____ (dd/mm/yyyy)

5 When did Deceased **first** consult a Physician for his / her last illness? _____ (dd/mm/yyyy)

6 Name & address of doctor Deceased **first** consulted for his / her last illness _____

_____

7 Please state names and address of every physician who attended to the Deceased during his / her last illness

Date of consultation (dd/mm/yyyy)	Date of admission (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Diagnosis	Name of doctor & address of hospitals/clinics

8 State the name and address of Deceased's regular doctor _____

_____

9 Are there other policies in force on Deceased's life taken with other companies ? ☐ Yes ☐ No

If yes, please give details:

Name of Company(s)	Commencement date (dd/mm/yyyy)	Policy no	Type of coverage	Sum assured

10 Death due to accident

a. Date of accident : _____ (dd/mm/yyyy) Time : _____ (am/pm)

b. Place of accident : _____

c. Why was the Deceased at the location ? _____

d. Describe in detail how the Accident happened ? _____

_____

e. Was the accident reported to the police? ☐ Yes ☐ No (If yes, please submit a certified copy of police report)

f. Was the accident reported in the newspaper? ☐ Yes ☐ No (If yes, please submit a copy)

g. Was an inquest or post-mortem carried out? ☐ Yes ☐ No (If yes, please submit a certified copy of post mortem report)

DECLARATION AND AUTHORISATION

I do solemnly and sincerely declare that I am the nominee/administarator/beneficiary for the policy money of the deceased and further declare as follows:-

withheld no material facts from the Company.

2. That any difference, if any, in respect of the details contained in the enclosed supporting document and the information presented to Etiqa Insurance Berhad (Etiqa) in this form refers to the same person. I understand and agree that Etiqa has the sole discretion to reject this application if the information given is false or insufficient.

3. That the original insurance policy whether or not enclosed therein (if any), due to loss or mutilated, belongs to the deceased.

4. And I hereby authorize any medical practitioner, surgeon person, hospital, clinic and any other institution or organization to furnish to Etiqa Insurance Berhad or its representative any information that maybe required concerning my health conditions, for settlement of this claim. I agree that Etiqa Insurance Berhad or its representative may use or disclose any of the information collected or held to third parties such as reinsurers, medical examiner or medical consultant, claims investigator and etc. within or outside Malaysia for the purpose of processing the claim. I agree that a photocopy of this authorization shall be considered as effective and valid as original.

5. I, agree, consent and allow Etiqa Insurance Berhad (hereinafter called "Etiqa Insurance") to process my personal data (including sensitive personal data) ('Personal Data') with the intention of processing this Claim Form, in compliance with the provisions of the Personal Data Protection Act 2010.

6. I, understand and agree that any Personal Data collected or held by Etiqa Insurance contained in this Claim Form may be held, used, processed and disclosed by Etiqa Insurance to individuals and/or organizations related to and associated with Etiqa Insurance or any selected third party (within or outside Malaysia, including medical institutions, solicitors, industry associations, regulators, statutory bodies and government authorities) for the purpose of processing this Claim Form and providing subsequent service related to it and to communicate with me for such purposes.

_____

Signature of Claimant

Full name _____

Contact No _____

Date _____

_____

Signature of Witness

Full Name _____

NRIC No _____

Contact No _____

Date _____

_____

Authorised Signature of Policy Holder & Company's Stamp

Full name _____

Designation: _____

Contact No _____

Date _____

LETTER OF AUTHORISATION / CONSENT
TO OBTAIN FURTHER INFORMATION (DEATH CLAIM)

To Whom It May Concern,

Dear Sir / Madam,

I hereby authorize and give my consent to any medical practitioner, physician, surgeon, clinic, hospital, medical centre, Insurance company or other organization, institution or individual concerned ("the Information Provider(s)') that may have any records or knowledge of the employment, financial, health or medical history of _____ (name of Life Assured) and to provide such information to Etiqa Insurance Berhad or its authorized agents and / or employees.

I expressly waive on behalf of myself and / or as a next-of-kin of the Life Assured and for his / her estate all provisions of law or professional ethics forbidding the Information or (Providers) from disclosing any such information acquired on the Life Assured in a professional and / or client capacity and I further release the Information Provider(s) and its agent / staff from any liability whatsoever that may arise, in supplying such information requested by the Company.

This authorization / consent is irrevocable and a copy of it will have the same effect and validity as the original.

_____

Signature / Thumb print of Next-of-Kin / Claimant

Name : _____

NRIC: _____

Old IC: _____

Relationship with Deceased: _____

Contact No: _____

Date: _____

Etiqa Insurance Berhad (9557T)
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