Insurance Claim Form for Insured Person/Premium Payor

Policy Number: _____ **ID Card/Passport No.:**_____

Life Insure Name: _____ **Owner Name:** _____

1. Claim information

Name: _____ ID Card/Passport No.: _____

Address: _____ Phone Number_____ Email:_____

Relation Between Policy Life Insure /Owner: _____

◯ Policy Owner ◯ Life Insure ◯ Incomer ◯ Other_____

2. Information of Life Insured/Premium Payor

I. Full Name: _____DoB:_____ ◯ As an Insured Person ◯ As an premium payor

Policy Number: _____ID Card/Passport No.: _____

Claim Details, please select:

◯ Death ◯ Total Permanent Disability (TPD)

◯ Cancer ◯ Stroke with Permanent Neurological Deficit ◯ Heart Attack with Specified Severity

◯ Other _____

II. Reason of Death/TPD

Reason of Death	Diagnosis	Date of Accident	Place of Accident	Date of Death/TPD	Place of Death/TPD
◯ Illness					
◯ Accident					

III. Before claim event, the insured person used to receive medical treatment from hospital/clinic or others as detailed below:

◯ No ◯ Yes Doctor Name: _____Hospital Name: ……Diagnosis: ……

……

IV. Occupation and workplace before claim event: _____

V. Has the Insured held other Policies with other companies?

◯ No ◯ Yes (If yes , please clarify more here)

Company name: _____ Sum Assured: _____

Policy Number: _____

3. Payment Method of Approved Claim

A. By Bank Transfer ◯ B. By Cheque ◯

Bank Name: _____ Pay to Claimant Name: _____

Account Holder Name: _____

Account Number: _____

Other Method (please specify): _____

4. Please attach all relevant supporting medical/diagnosis document

1) Declaration of Attending Physician
2) Certified copy of death/TPD certificate
3) Certified true copy of the ID card of life insured/premium payor
4) Certified copies of IDs of all beneficiaries
5) Police Report in case of death/TPD caused by accident
6) Certified copy of autopsy examination report (if any)
7) Medical/Health document records before insured claim event
8) Other document(s) as required .....

5. Declaration and Authorization to Release Information

My name: _____ ID No./Passport No. :_____

Date of Birth: _____ Gender: _____

My current address: _____

phone number: _____

My relationship to Life Insured or Payor: _____

◯ Yes, I am a beneficiary ◯ No, I am not a beneficiary. Please specify: _____

a. All information provided by me for this claim is completed and true to the best of my knowledge and belief.

b. I hereby give consent to the attending physician(s) or hospital(s) or any clinic(s) that has or had provided the deceased/ the disabled (life insured/payor) with medical treatment to disclose the medical treatment history or other details pertaining to the treatment and health check result to FWD.

c. I authorize FWD or agent of the Company to act as legal representative to proceed and contact to receive the afore-mentioned medical history form attending physician(s) or hospital(s) or any clinic(s) that has or had provided the deceased/ the disabled with medical treatment as if they were my own actions in all aspects.

d. If a claim is submitted by me as the policy owner or beneficiary whom known as the proper claimant, then I confirm that I have obtained the necessary authorization from the Life Insured/Payor to:
1). Supply his/her information to FWD and
2). Transfer all supplied information from FWD to me. I also understand that the information requested in this claim is required in order for FWD to process my claim request. I also hereby give my consent to FWD to disclose my personal information to other insurance companies or its reinsurance company or legal authority or medical profession personnel for the Company's claim assessment or contractual claim payment or medical use.

e. I also hereby agree with and authorize FWD to deduct from the claim payment, in the event that, I have any shortfall, for whatever reason. FWD also has the right to reverse or claim back any incorrect payment caused by incorrect or omission of required information provided in processing the claim.

f. I am not a US citizen, US resident or US permanent resident or alien (green card holder).
◯ No ◯ Yes
If the answer is Yes, please provide more information_____

Signature/Thumbprint of proper Claimant: _____ Name: _____Date: _____

Signature/Thumbprint of Agent/Insurance Specialist/Witness: _____ Name: _____Date:_____

For non-death claim: Life Insured/Payer, please sign below:

Signature/Thumbprint of Life Insured/Payor: _____ Name: _____Date: ___