FWD insurance

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# Insurance Claim Form

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|---|---|---|---|
| Policy Number: | | Life Insured: | |
| Policy Owner: | | ID Card/Passport No.: | |

## 1. Claimant Information

Name: _____ ID Card/Passport No.: _____

Address: _____

Phone No.: _____ Email: _____

Relationship with Life Insured /Policy Owner:

☐ Policy Owner ☐ Beneficiary ☐ Other _____

## 2. Detail information of Claim Event

1. Full Name: _____ Date of Birth: _____

ID Card/Passport No.: _____ ☐ As Life Insured ☐ As Premium Payor

Claim Details, please select:

☐ Death ☐ Total Permanent Disability (TPD) ☐ Cancer/Critical Illness:

- ☐ Early Stage of Cancer
- ☐ Late Stage of Cancer
- ☐ Stroke with Permanent Neurological Deficit
- ☐ Heart Attack with Specified Severity
- ☐ Other: _____

2. Claim Details, please select:

☐ Illness Diagnosis: _____ Date of Death/TPD: _____ Hospital: _____

☐ Accident Place of Accident: _____ Date of Accident: _____

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

☐ No ☐ Yes (If yes, please details)

Doctor Name: _____ Hospital Name: _____ Diagnosis: _____

4. Occupation and workplace before claim event: _____

5. Has the Life Insured held other Policies with other companies?

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

Company name: _____

Policy Number: _____ Sum Assured: _____

## 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 documents

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

## 5. Declaration and Authorization to Release Information

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 from 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 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).

☐ Yes ☐ No (If the answer is No, 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:

_____ _____ _____