CHUBB®

Home Payment Care
Claim Form

SG020

Policy No.:

Section A: Particulars of Policyholder/Insured Person/Claimant

Name of Policyholder: DBS Bank Ltd

Name of Insured Person (As shown in NRIC/Passport):

NRIC/Passport No.: Nationality: Gender: Male Female Date of Birth: DD / MM / YYYY

Mailing Address of Insured Person:

Postal Code:

Tel No. (Mobile): Occupation:

Email:

Name of Claimant (As shown in NRIC/Passport) - If different from Insured Person:

NRIC/Passport No.: Nationality: Gender: Male Female Date of Birth: DD / MM / YYYY

Mailing Address of Claimant:

Postal Code:

Tel No. (Mobile): Occupation:

Email:

Section B: Payment of Claims

Any benefits payable under this Policy shall be paid to the Policyholder and/or the Insured Person or his estate in accordance with this Policy.

Section C: Involuntary Loss of Employment Benefit

Name of Employer:

Date of Employment: DD / MM / YYYY Date of Retrenchment/Business cease (Bankruptcy): DD / MM / YYYY

Employment Type: Permanent Contract Temporary Self-Employed

Reason for Retrenchment/Termination

Section D: Accidental Death/Accidental Permanent Disability Benefit
(Please enclose a copy of police report if accident is due to road traffic accident)

Date of Accident: DD / MM / YYYY Time of the Accident (24-Hour): HH : MM

Country of Accident: Place of Accident:

Chronology and description of the accident/loss and detail the injuries sustained (Please use supplementary sheet if necessary)

Has the insured person previously suffered this or a similar condition or a recurrence of a previous injury? Yes No

If **Yes**, please give details: _____

Was the insured person under the influence of alcohol, medication, drugs or any other intoxicating substance at the time of accident? Yes No

If **Yes**, please provide details of name/type of alcohol, medication, drugs or intoxicating substances.

Details of Hospitalisation (If applicable - please attach In-Patient Discharge Summary)

Name of Hospital:

Period of Hospitalisation: From DD / MM / YYYY To DD / MM / YYYY

Was the insured person referred by a General Practitioner/Specialist/other Hospital? Yes No

If **Yes**, please provide the name of the General Practitioner/Specialist/Hospital:

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Section E: Declaration

Did you remember to enclose the following? (Where applicable)

Document	Yes	N/A
Retrenchment/Termination letter from the relevant person or department within the insured person's employer stating employment details	☐	☐
A copy of the insured person's CPF Contribution History Statement for the period of unemployment	☐	☐
Bankruptcy Order and any other documentary evidence required by us for the insured persons who are self-employed	☐	☐
Traffic Police report (If involved in a road accident)	☐	☐
Driving license (If the insured person was driving at the time of accident)	☐	☐
Written notes from Physician on type of injury sustained/Inpatient Discharge Summary or Medical Report	☐	☐
Death certificate and letters of administration/probate (If applicable)	☐	☐
Autopsy and Toxicology report	☐	☐
Coroner's Inquiry report; Police Investigation reports and findings on the alleged accident; and Incident Report lodged by the employer (If applicable)	☐	☐

By signing this form, I/We agree that Chubb will use the information supplied here and during the formation and performance of my policy, for policy administration, customer services, claims handling and fraud analysis and prevention, and that Chubb may disclose such information to its service providers, agents, authorities and other parties for these purposes.

I/We hereby authorise any hospital, physician, and any other person or entity who has attended to or examined me, to furnish to Chubb or its authorised representatives, any and all information with respect to any illness or injury or loss, medical history, consultation, prescriptions or treatment, copies of all hospital, medical or other records, investigation status and results, and such personal information as Chubb in its absolute discretion considers relevant for its assessment of my claim. A photostatic copy of this authorisation shall be considered as effective and valid as the original.

I/We do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I/We agree that if I/We have made or in any further declaration or representation shall make any false or fraudulent statements or suppress, conceal or falsely state any fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past, present or future claims shall be forfeited.

Name of Insured Person	Signature of Insured Person	Date (DD/MM/YYYY)
Name of Claimant (If different from Insured Person)	Signature of Claimant (If different from Insured Person)	Date (DD/MM/YYYY)

Please click on the button to submit your claim form: **Submit**

Contact Us

Please visit our website at www.chubb.com/sg or contact us at +65 6398 8797 or DBS.Claims.SG@Chubb.com.

Chubb. Insured.™

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