Personal Accident - Death

Claim Form

SG020

CHUBB®

Important Information

1) Claimant is requested to state, as fully and accurately as possible, the information asked for below.

2) Please attach a Certified Copy of the Death Certificate, Police Report, Coroner's Inquiry/Autopsy and Toxicology Report.

3) For group Personal Accident (Accidental Death) claim, please attach Documentary Proof of the Commencement Date of Employment and confirming that the Deceased was an employee of the Policyholder prior to the time of death (E.g. Certified Copy of Pay Slip).

4) If death occurred overseas, please attach burial/cremation documentation and letter from Immigration & Checkpoints Authority (ICA) confirming the invalidation of Deceased's Singapore NRIC/Passport. Documents must be authenticated by either of the following:

i) Singapore Embassy in the country of death;

ii) Singapore Consulate; or

iii) Notary Public.

5) All documents submitted must be in English. Any document that is not in English must be accompanied by an English translated copy of the document made by a certified translator/interpreter.

6) Any documentary proof and/or other reports required by Chubb Insurance Singapore Limited (Chubb) shall be furnished at the expense of the Claimant.

The issue and acceptance of this form does NOT constitute an admission of liability by Chubb or waiver of its rights.

Section A: Particulars of Policyholder/Deceased and Claimant

Name of Policyholder (as shown in NRIC/Passport):

Address of Policyholder:

Postal Code:

Policy No.:

Period of Insurance: From: To:

Tel No. (Mobile): Tel No. (Residence):

Tel No. (Office): Marital Status: Single Married Widowed

Date of Birth: DD / MM / YYYY Age:

Gender: Male Female Relationship to Deceased (if applicable):

Occupation: Date of Employment:

Name of Employer:

Date of Death (if applicable): Place of Death (if applicable):

Cause of Death (if applicable):

Name of Deceased (as shown in NRIC/Passport) - if Deceased and Policyholder are two different persons:

Address of Deceased:

Postal Code:

Gender: Male Female Marital Status: Single Married Widowed

Date of Birth: Age:

Date of Death: Place of Death:

Cause of Death:

Occupation: Date of Employment:

Name of Employer:

Basis of Insurance/Category of Deceased Covered:

Please provide details of every physician who has attended to the Deceased in the last five years and state the nature of illness and/or disease. (Please use supplementary sheet if necessary)

Name of Physician	Address of Physician	Nature of Illness

Was the Deceased holding any life, personal accident and/or hospitalisation policy/policies with any other insurance companies?
If **Yes**, please furnish with details below (Please use supplementary sheet if necessary)

Name of Insurance Company	Policy Type	Date Insurance Effected	Amount Insured

Name of Claimant (as shown in NRIC/Passport) - if different from Policyholder:

Address of Claimant:

Postal Code:

NRIC/Passport No.: Occupation:

Nationality: Age:

Tel No. (Mobile): Tel No. (Residence):

Tel No. (Office): Gender: Male Female

Date of Birth: Relationship to Deceased:

Email:

Section B: Details of Accident

Date of the Accident: Time of Accident:

Country of Accident: Place of Accident:

When and Who discovered the Accident:

Relationship of person to the Deceased:

Chronology and Description of the Accident (Please use supplementary sheet if necessary).

Were there witnesses to the incident at the material time? ☐ Yes ☐ No
If **Yes**, please provide details below:

	Witness 1	Witness 2
Name:		
Address:		
NRIC:		
Contact Number:		

Was the Insured under the influence of alcohol, medication, drugs or any other intoxicating substance at the time of accident? ☐ Yes ☐ No
If **Yes**, please provide details below (Please use supplementary sheet if necessary):

Name/Type of Alcohol, Medication, Drugs or Intoxicating Substances	Quantity Consumed	Date And Time Consumed

Has this accident been reported to the Ministry of Manpower (MOM)? ☐ Yes (please attach a copy of the I-REPORT) ☐ No
If **No**, please state reason(s) the accident was not reported to the MOM:

Please provide details of the Police Station to which the accident was reported to and attach the police report:

Name of Police Station:

Date of Report: Time of Report (24-Hour):

Was the deceased admitted to a hospital prior to death? ☐ Yes ☐ No
If **Yes**, please provide details of the Hospital and attach the medical report:

Name of Hospital:

Address of Hospital:

Postal Code:

Section C: Declaration

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

Document	Yes	N/A
Death Certificate, Police Report, Medical Report, Completed Attending Physician's Statement	☐	☐
Autopsy Report, Post Mortem Report, Toxicology Report	☐	☐
Coroner's Inquiry Report; Police Investigation reports & findings on the alleged accident; and Incident Report lodged by the employer (if applicable)	☐	☐
Driving License (if deceased was driving at the time of accident)	☐	☐
Letter of Administration or Receipt of Probate (if applicable)	☐	☐

All documents submitted must be in English. Any document that is not in English must be accompanied by an English translated copy of the document made by a certified translator or interpreter.

By signing this form, I agree that Chubb will use the information supplied here and during the formation and performance of the 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 hereby authorise any hospital, physician, and any other person(s) or entity who has attended to or examined the deceased, 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 this claim. A photostatic copy of this authorisation shall be considered as effective and valid as the original.

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that if I 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.

Signature of Policyholder
(Please affix company stamp if applicable)

Date

Signature of Claimant
(if different from Policyholder)

Date

Name of Insured's Direct Manager
(for corporate policies)

Signature of Insured's Direct Manager
(for corporate policies)

Date

Note:

Kindly submit the completed claim form through your Broker or via email to AHClaims.SG@Chubb.com. Please ensure that the relevant supporting documents are submitted as well.

Contact Us

Please visit our website at www.chubb.com/sg or contact us at +65 6398 8000.

Section D: Attending Physician's Statement (To be completed by attending physician)

Name of Patient:

NRIC/Passport No.: Gender: Male Female Date of Birth:

Date on which you first saw the Patient:

Is it due to Sickness or Injury? Sickness Accident on

Was the Patient referred to you by another doctor? If so, please furnish with Name and Address of Referral doctor.

Name of Doctor:

Address:

What symptoms did the Patient complain of?

According to the Patient, how long had he/she been experiencing these symptoms?

In your opinion, how long do you feel the symptoms had lasted?

Had the Patient previously seen any other doctor or receive treatment on account of these symptoms?
If so, please give details:

What was the primary caused of death?

Was there any other significant conditions or illness(es) which may have contributed to the death? Yes No
If **Yes**, please provide details:

Give details of any circumstances, such as the influence of alcohol, or any other drugs and substances which may have contributed to the death.

Was the death due to deliberately self-inflicted injury, suicide, or criminal or illegal acts?
If **Yes**, please provide details:

I hereby certify that I have personally examined and treated the patient for the above injury/sickness and that the facts as given above present my opinion of his/her condition.

Name of Physician

Qualification

Official Address

Tel/Fax

Signature with Official Stamp

Date

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

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Published 03/2023.