LIFE INSURANCE CORPORATION (SINGAPORE) PTE LTD

INSTRUCTIONS AND CHECKLIST FOR DEATH CLAIM

- All the relevant columns should be completed. Mark" N/A" if not applicable.
- Copies of the documents submitted should be certified by LIC's Officers or by a Singapore lawyer.
- The cost for completing the Physician's Report is to be borne by the claimant.

CHECKLIST OF DOCUMENTS TO BE SUBMITTED

Claim form Part-1 (statement to be completed by the Claimant)	
Claim form Part-2 (Physician's Statement: to be completed by the physician)	
Certified true copy of the Death Certificate of the deceased	
Original Insurance Policy document	
Certified true copy of the Birth Certificate of the deceased	
Certified true copy of the Birth Certificate of the Claimant (s)	
Certified true copy of the identity of the Claimant (s). (NRIC / Passport)	
Certified true copy of Marriage Certificate of the deceased	
Certified copy of the Last Will	
ADDITIONAL REQUIREMENTS IN CASE OF AN ACCIDENTAL OR UNNATURAL DEATH	
Police Investigation Report	
Coroner's Report	
Post Mortem / Autopsy Report	
Toxicological Report	
ADDITIONAL DOCUMENTS REQUIRED IF DEATH OCCURRED OVERSEAS	
Repatriation Report (if body was repatriated to Singapore)	
Letter from Immigration and Checkpoint Authority (ICA) confirming receipt of the Singapore IC, Passport and overseas Death Certificate.	

LIFE INSURANCE CORPORATION (SINGAPORE) PTE LTD

POLICY SERVICE DEPARTMENT
3 Raffles Place, #07-01 , Bharat Building,
Singapore 048617
email: crm@licsingapore.com

DEATH CLAIM FORM: PART 1- CLAIMANT'S STATEMENT

A. POLICY DETAILS		
Policy Number(s)		
B. PARTICULARS OF THE DECEASED		
Name of the Deceased\	Date of Birth(dd/mm/yyyy)	NRIC No. (If deceased is not a Singapore Citizen, please provide FIN / Passport No.)
C.PARTICULARS OF THE CLAIMANT		
Name of the Claimant	Contact Number	NRIC No. (If the claimant is not a Singapore Citizen, please provide FIN / Passport No.)
Claimant's Address	Relationship to the deceased	Capacity / Title under which the claim is made.
D. TESTAMENT AND FAMILY STATUS		
1. Did the deceased leave a Will?	☐ Yes ☐ No	If 'Yes', submit a certified copy of the Last Will.
2.Was a Grant of Probate or Grant of Letters of Administration applied for?	☐ Yes ☐ No	If 'Yes', submit a certified copy of the Grant of Probate / Grant of Letters of Administration
3.Marital status of the deceased	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	

E. DETAILS OF DEATH		
1. Country and place of death. Please specify the name and address of the hospital if death occurred in the hospital		
2. Date of death	_____/____/_____ (dd/mm/yyyy)	
3. Cause of death		
4. Was death due to suicide?	☐ Yes ☐ No	
5. Was a Coroner's inquest held?	☐ Yes ☐ No	If 'Yes', submit a certified copy of the Coroner's Inquiry Report
6.Was an autopsy / post-mortem held?	☐ Yes ☐ No	If 'Yes', submit a certified copy of the Post Mortem or Toxicology Report

F.OTHER INSURANCE

Was the deceased insured with any other companies? ☐ Yes ☐ No If 'Yes', please give the information requested below

Name of the Company	Policy Number	Date of Issue (dd/mm/yyyy)	Sum Insured (S$)		

G. IF DEATH WAS DUE TO NATURAL CAUSES

1.The date the deceased first complained about or displayed symptoms of the last illness.	_____/____/_____ (dd/mm/yyyy)
2.The date the deceased first consulted a physician for the last illness.	_____/____/_____ (dd/mm/yyyy)

3.Details of the physician who last attented the deceased for his/ her illness:

Name of the Doctor	Name /Address of Clinic / Hospital	Date of consultation	Disease / Symptom

H .IF DEATH WAS DUE TO ACCIDENT OR UNNATURAL CAUSES			
1.Please state the place ,Date and time of the accident	Place of Accident	Date of Accident (dd/mm/yyyy)	Time of Accident
2. Description of the Accident			
3.Was the accident reported to the police?	☐ Yes ☐ No	If 'Yes', submit a certified copy of the Police Investigation Report	

I. IF DEATH OCCURRED OVERSEAS			
1.Please state the date the deceased left Singapore, purpose and intented length of visit.	Date of leaving Singapore (dd/mm/yyyy)	Purpose of overseas travel	
2.Was the deceased cremated / buried overseas?	☐ Yes ☐ No	If 'Yes', submit a certified copy of the cremation / burial permit /document.	
3. Is the Letter from ICA (Immigration and Checkpoint) confirming invalidation of Singapore IC / Passport enclosed?	☐ Yes ☐ No		

J. DECLARATION BY THE CLAIMANT

1.I, _____ hereby declare that the above statements are true and complete and that I have not withheld any material fact from Life Insurance Corporation and I make this solemn declaration believing it to be true and by virtue of the provisions of the Statutory Declaration Act,1835.

2.I hereby consent to Life Insurance Corporation from seeking information from any hospital,physician,person or organisation that maybe required regarding the deceased and I authorise the giving of such information to Life Insurance Corporation. A photocopy of this authorisation shall be considered as valid as the original.

_____ _____

Date(dd/mm/yyyy) Signature of the Claimant

LIFE INSURANCE CORPORATION (SINGAPORE)
Customer Service, 3 Raffles Place, #07-01
Bharat Building, Singapore 048617
Tel + 65 62234797. email:crm@licsingapore.com

DEATH CLAIM FORM; PART-2. PHYSICIAN'S STATEMENT

1.Name of the deceased	NRIC / Passport / FIN number	Occupation
2.What is the primary cause of death	00.What were the symptoms prior to death	
00. When was the illness first diagnosed?	00. What were the treatments given?	

00 Was the death due to any habits, family history, occupation or previous sickness? If "Yes" please give details

00 Did the deceased suffer from any other disease? If "Yes" please give details below.

Illness	Period of illness	Date of Diagnosis	Treatment given

Please give below details of other Physicians who had attended to the deceased during the last three years

Name and Address of the Physician	Period of consultation	Illness / Condition

Was the death due to suicide or self-inflicted injury? If "Yes" please give details.

Was the death due to an accident? If "Yes" please give details.

Name of the Doctor:_____

Qualification : _____

Signature : _____

Date: : _____

Hospital / Official Stamp