Dear Claimant,

We’re sorry to receive notice of the death claim. To enable us to process your claim, please follow the instructions provided below:

INSTRUCTIONS

HOW TO FILE A DEATH CLAIM

Documents Required:

1. Death Claim Form: Section 1 – Claimant’s Statement (to be completed by Claimant)
2. Death Claim Form: Section 2 – Physician’s Statement (to be completed by the attending physician who attended the deceased in his/her last illness or accident)
3. Clinical Abstract Application Form
4. Certified True Copy of Death Certificate
5. Copy of the NRIC/FIN or Passport of the deceased
6. Certified True Copy of the NRIC/FIN or Passport of the Claimant
7. Any other documents that support the claim (e.g. official certificate of appointment of the legal guardian of minor’s beneficiary)
8. Proof of Claimant’s relationship with deceased as follows (where applicable):

<table>
<thead>
<tr>
<th>Claimant</th>
<th>Documents required (Certified True Copy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>Marriage Certificate of Claimant</td>
</tr>
<tr>
<td>Children</td>
<td>Birth Certificate of Claimant</td>
</tr>
<tr>
<td>Parent</td>
<td>Birth Certificate of deceased</td>
</tr>
<tr>
<td>Sibling</td>
<td>Birth Certificate of deceased and Claimant</td>
</tr>
</tbody>
</table>

Additional documents required if death was due to an Unnatural / Accident OR occurred overseas:

9. Newspaper Clipping (if any)
10. Police Investigation Report
11. Coroner’s Inquest
12. Post Mortem and Toxicology Report
13. Burial / Cremation Documentation
14. Letter from ICA (Immigration and Checkpoint) confirming the invalidation of Deceased’s Singapore IC/Passport – if death occurred overseas

IMPORTANT NOTE:

1. All questions in the Claimant’s Statement must be fully and truthfully answered. We reserve the right to pursue for any documents that are not mentioned above if they are deemed necessary.
2. These said documents shall be in the forms as prescribed by Aviva Ltd and shall be furnished at the expense of the Claimant(s).
3. The cost of the Physician’s Statement and/or medical evidence shall be borne by the Claimant(s).
4. For Physician’s Statement or reports to be obtained from hospitals, specific Clinical Abstract Forms may be used. Please refer to the respective hospital’s website for details. For clinics, please use Aviva’s Clinical Abstract Application Form.
5. Copies of the document(s) may be certified to be true copies by Aviva’s distributors or Customer Service Executives at Aviva’s Customer Service Centre or a Solicitor. Please note that the original documents have to be produced for certification. For death which occurred overseas, original Death Certificate and supporting documents can only be certified by the Notary Public of the Country where Life Assured passed away.
6. 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. In addition, a certificate stating the proficiency of the translator in the language being translated must also be submitted.
7. If the Policy has been assigned, original Assignment Deed is required.
8. All claims required documents can be submitted to Aviva Ltd through the Aviva’s distributors. Alternatively, you may submit the claim personally to our Customer Service Centre.
9. For the purpose of FATCA, a U.S. Person means:
   (a) A citizen or lawful permanent resident (including US green card holder) of the U.S.; or
   (b) A partnership or corporation organised in the US or under the laws of the U.S. or any State thereof, or a trust if:
      (i) A court within the U.S. would have authority under the applicable law to render orders or judgments concerning substantially all
          issues regarding the administration of the trust; and (ii) one or more US persons have the authority to control all substantial
          decisions of the trust, or an estate of a decedent that is a citizen or resident of the U.S.

The definitions above will be interpreted in accordance with the provisions of the U.S. Internal Revenue Code.
CLINICAL ABSTRACT APPLICATION

To whom it may concern:

__________________________________________
__________________________________________
__________________________________________
__________________________________________

Dear Sir/Madam

Please furnish AVIVA LTD with a detailed medical report on:

__________________________________________  NRIC / BC _____________________

(Name of Patient)

This report is required for insurance purposes. Upon receipt of this application from AVIVA LTD, you may furnish a detailed medical report (together with histology report, laboratory results, etc.) whether for use in connection with litigation or for other legitimate purposes.

I agree that a copy of this authorisation form shall be considered as effective and valid as the original.

__________________________________________
Signature of Next-Of–Kin

Name   : ___________________________________
Address : ___________________________________
          ___________________________________
NRIC No : ___________________________________
Date    : ___________________________________
Relationship to Patient / Deceased : _________________
**DEATH CLAIM – CLAIMANT’S STATEMENT**

**IMPORTANT:**
Please refer to the instructions under *How to file a Death Claim* in page 1 before completing this form.

*Copies of the document(s) may be certified to be true copies by our Aviva’s Advisor or Customer Service Executives at Aviva’s Customer Service Centre or a Solicitor. Please note that the original documents have to be produced for certification.*

### SECTION 1 – To be completed by the Claimant

**POLICY NUMBER(S):**

1) Name of Assured/PolicyOwner

<table>
<thead>
<tr>
<th>ID/FIN/Passport/BC No</th>
<th>Date of Birth</th>
<th>Marital Status</th>
</tr>
</thead>
</table>

2) Name of Deceased (if other than Assured/PolicyOwner)

<table>
<thead>
<tr>
<th>ID/FIN/Passport/BC No</th>
<th>Date of Birth</th>
<th>Marital Status</th>
</tr>
</thead>
</table>

3) Relationship of Deceased to Policyholder

4) Place of Birth of Deceased

5) Date of Death

6) Cause of Death

7) Resident at Time of Death

8) Place of Death

9) Was the Cause of Death Work-Related  ☐ Yes  ☐ No

10) Occupation of Deceased

11) If cause of death is a result of Illness, please state

<table>
<thead>
<tr>
<th>Date Illness 1st Commenced</th>
<th>Symptom 1st Presented</th>
<th>Date 1st Treated</th>
<th>Name &amp; Address of Doctor</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

12) Name And Address Of All Physicians Who Attended During His/Her Last Illness/Injury and in the last 3 years

<table>
<thead>
<tr>
<th>Name &amp; Address of Doctor</th>
<th>Date First &amp; Last Consulted</th>
<th>Reason for Consultation(s)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
### 13) If cause of death is a result of an Accident or Unnatural cause, please state

<table>
<thead>
<tr>
<th>a) Date &amp; Time of Accident</th>
<th>b) Place &amp; Country of Accident</th>
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</thead>
<tbody>
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<td></td>
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</tbody>
</table>

**c) Please describe and provide details on how the accident occurred.**

<table>
<thead>
<tr>
<th>d) Was a police investigation carried out?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

If “Yes”, please provide copy of report and complete the following:

- **Name of Investigation Office-In-Charge**
- **Police Station (Branch & Address)**

### 14) Was the death due to Self-Inflicted (e.g. suicide)?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

### 15) Was a Post-Mortem or Autopsy carried out?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

If “Yes”, please provide a certified true copy of the report

### 16) Was a Coroner’s Inquest held?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If “Yes”, please provide a certified true copy of the Coroner’s Inquiry Report

### 17) Did the Deceased leave a Will?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

If “Yes”, please provide a certified true copy of the Last Will & Testament

### 18) Was a Grant of Probate or Letters of Administration applied for?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

If “Yes”, please provide a certified true copy of the Grant of Probate or Grant of Letters of Administration.

### 19) Who are the Surviving Family Members of the Deceased?

### 20) In what Capacity or by what Title do you claim the Assurance? Please indicate your relationship with the Deceased:

### 21) Is the Deceased insured with other Insurance Company?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

If “Yes”, please state

- **Name of Insurance Company**
- **Policy No.**
- **Sum Assured**
CLAIMANT’S DECLARATION AND AUTHORISATION

I/We, do solemnly and sincerely declare that the answers given to the above questions are true to the best of my/our knowledge and belief and that no material fact has been concealed from the Company and I/we make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the Statutory Declaration Act, 1835.

I/We declared that I am/we are not an undischarged bankrupt. There are currently no actual or pending bankruptcy proceedings against me/us and I/we have not assigned the Policy to any other party.

I/We further hereby consent to AVIVA LTD seeking information from any hospital, physician, person or organisation that may be required regarding the abovenamed deceased and I/we authorize the giving of such information to Aviva Ltd. A photocopy of this authorization shall be considered as effective and valid as the original.

I/We consent to Aviva Ltd (and Aviva related group of companies) collecting, using and/or disclosing my/our personal data for the processing of the above transaction and such other purposes ancillary or related to the administering of the policy(ies), account(s) and/or managing my/our relationship with Aviva Ltd.

I/We also consent to Aviva Ltd (and Aviva related group of companies) transferring my/our personal data to Aviva Ltd related group of companies and/or third party service providers, reinsurers, suppliers or intermediaries whether located in Singapore or elsewhere, for the above purposes.

For full details of the purposes of collection, use and disclosure of your personal data, please visit http://www.aviva.com.sg/pdpa.html.

CLAIMANT’S DECLARATION ON U.S. PERSON STATUS (please tick the box as appropriate)

☐ I/We hereby declare and agree that I/We do NOT have any U.S. indicia (i.e. U.S. citizenship, residency, place of birth, taxpayer identification number, mailing/residential address or contact number) and I/We am/are NOT a U.S. person for U.S. federal income tax purposes, and that I/We am/are not acting for, or on behalf of a U.S. person. I/We understand that Aviva Ltd, believing this statement to be true, will rely on it and act on it.

☐ I/We hereby declare and agree that I/We have one or more U.S. indicia – (please circle relevant indicia) U.S. citizenship, residency, place of birth, taxpayer identification number, mailing address, residential address, contact number – but I/We am/are NOT a U.S. person for U.S. federal income tax purposes, and that I/We am/are not acting for, or on behalf of a U.S. person. I/We understand that Aviva Ltd, believing this statement to be true, will rely on it and act on it.

Please submit W-8BEN/W-8BEN-E Form (whichever is applicable) together with documentary evidence such as Passport or ID card, tax certificate of residence, certificate of loss of nationality or its equivalent.

☐ I/We hereby declare and agree that I/We am/are a U.S. person for U.S. federal income tax purposes. Please submit W-9 Form.

I/We understand that Aviva Ltd is obliged to provide to any governmental authority including the Inland Revenue Authority of Singapore (IRAS) and/or the U.S. Internal Revenue Service (IRS), with information on U.S. persons who may have received proceeds under cash value or annuity contracts with certain prescribed amount at any time during the calendar year. By signing on this Claims form, I/We:

(i) declare that the information provided above is correct;
(ii) consent to the disclosure of personal data and information relating to the Policy, and Applicant/Trustee/Assignee/Claimant/Beneficiary to any governmental authority including the IRAS and/or IRS, and shall provide such personal data and information as may be required by Aviva Ltd from time to time to fulfill its contractual, legal and regulatory obligations;
(iii) agree that in the event this declaration is untrue, Aviva Ltd reserves the right to cancel or terminate the Policy or provide the necessary information to IRAS or IRS (as the case may be) to fulfill its reporting obligations, without being liable to the claimant whatsoever;
(iv) will be responsible for my/our own tax liabilities and obligations within or outside Singapore, which may be due under or in connection with this claim or the Policy, and will seek such tax advice at my/our sole costs and expense;
(v) declare that Aviva Ltd has not and will not provide me/us with any U.S. tax compliance or planning advice and I/We will not hold Aviva Ltd liable whatsoever for any adverse tax consequences suffered by me/us as a result of this claim and/or the Policy;
(vi) agree that if my/our tax status have changed to a U.S. tax status and/or I/We have become U.S. citizen or resident, I/We will notify Aviva Ltd within 30 days of the change.

Signature of Claimant: ___________________________ Date: ___________________________
Name of Claimant: ___________________________ Telephone no.: ___________________________
NRIC/FIN No.: ___________________________ Email: ___________________________
Address: ___________________________
DEATH CLAIM – PHYSICIAN’S STATEMENT

1) Name of Deceased

2) Name of Deceased’s Company

3) Date of Death

4) Cause of Death

5) Place of Death

6) What was the underlying cause of Death?

7) How long has the illness been existed prior to Death?

8) Did Deceased have any symptoms prior to Death?  [ ] Yes  [ ] No  If “Yes”, please state

   a) Date symptoms First started
   e) When did Deceased First consult you for this condition?

   b) Symptoms presented
   f) When did Deceased Last consult you for this condition?

   c) Nature of Treatment rendered
   g) Date of Treatment rendered

   d) Date of Diagnosis
   h) Exact Diagnosis

9) Was the Deceased informed of the diagnosis?  [ ] Yes  [ ] No  If “Yes”, when was the Deceased first told?

10) Did Deceased suffer from any other illnesses?  [ ] Yes  [ ] No  If “Yes”, please state

<table>
<thead>
<tr>
<th>Illness</th>
<th>Date of Diagnosis</th>
<th>Date &amp; Type of Treatment</th>
<th>Name &amp; Address of Doctor</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

11) Was the Death in any way partly attributed to Deceased’s habits, family history, occupation OR previous diseases?  [ ] Yes  [ ] No  If “Yes”, give details.

Date : ______________________________

Name of Doctor : ______________________________

Professional Qualification : ______________________________

Signature of Doctor : ______________________________

Clinic or Hospital Stamp