Income Insurance Limited | UEN: 202135698W
Income Centre 75 Bras Basah Road Singapore 189557
Tel: 6788 1777 · Fax: 6338 1500
Enquiries: www.income.com.sg/enquiry

Dear Customer, please email your claim to groupclaim@income.com.sg to avoid delay in the processing.

Checklist for Death Claim (Group Insurance Policies)

Dear claimant
We are sorry to learn of the death of our policyholder/insured. In order for us to process your claim, please complete this form in FULL and attach the following documents:

Important notes
(a) All items must be duly completed to avoid delay in the claim processing. Please indicate as "N.A." if not applicable.
(b) Upon receipt of ALL the required documents, we will process your claim and inform you of the outcome as soon as possible. For each item provided, please tick (√) if applicable.
(c) All overseas documents must be certified as true copies by your lawyer or any Notary Public.
(d) All documents submitted must be in English. Any documents which are in foreign languages must be officially translated to English by a certified translator/ interpreter.
(e) For policy with nomination, the death claim form should be completed by each of the nominee(s).

_____ Death Claim Form (to be completed by nominee/claimant)

_____ Certified True Copy of Death Certificate (for overseas death, the original Death Certificate must be certified by your lawyer or any Notary Public)

_____ Letter from Immigration and Checkpoint Authority (ICA) - this letter is issued by ICA for Singaporeans or Permanent Residents (PR) who died overseas. It confirms receipt of the Singapore IC, Passport and overseas Death Certificate.

_____ Repatriation Report (if body was repatriated to Singapore for cremation/burial)

_____ Cremation/burial permit (if cremation or burial occurred overseas)

_____ NRIC or relevant identification documents (e.g. passports, birth certificates) of claimant(s)

_____ Proof of claimant's relationship with deceased (please refer to the next page for supporting documents for proof of relationship)

_____Newspaper Clipping and Police Report (if death was due to accidental or violent causes)

_____ Last Will of deceased (if deceased had left a Last Will)

_____ Latest pay slip of deceased

Submission of documents
Please submit your documents through your company.

DOCUMENTS FOR PROOF OF RELATIONSHIP

GROUP INSURANCE POLICIES – WHERE CLAIMANT IS NEXT OF KIN

TYPE OF POLICY	CLAIMANT	DOCUMENTS TO SUBMIT
Group Insurance Policy	Spouse	• NRIC of Spouse • Marriage Certificate of Spouse
	Parent	• NRIC of Parent • Birth Certificate of Deceased
	Child	• NRIC of Child • Birth Certificate of Child
	Sibling	• NRIC of Sibling • Birth Certificate of Deceased • Birth Certificate of Sibling

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Death Claim Form (Group Insurance Policies)

Important Notice
The acceptance of this form is NOT an admission of liability on the part of Income. Any documentary proof or report required by Income shall be furnished at the expense of the policyholder or claimant (depending on plan types). To avoid delay in processing your claim, please email the duly completed claim form together with the supporting documents to groupclaim@income.com.sg within 30 days from date of occurrence.

Policy number(s)	Plan type	Claim number

Particulars of deceased

Full Name (as shown in NRIC, FIN or Passport)	NRIC/Passport/Birth Certificate number
Occupation	Date last at work (dd/mm/yyyy)
Name and address of employer (or last employer if deceased was unemployed)	Residential address

Details of death

Date of death (dd/mm/yyyy)	Cause of death
Place of death (Specify hospital name if death occurred in hospital)	Was the death due to suicide? ☐ Yes ☐ No
For death occurring outside Singapore, was the deceased buried or cremated outside Singapore? (If "Yes", please enclose a copy of the burial or cremation permit.)	☐ Yes ☐ No
Was a post-mortem or autopsy carried out? (If "Yes", please enclose a copy of the report.)	☐ Yes ☐ No
Was any Coroner's Inquest held? (If "Yes", please enclose a copy of the Coroner's Inquiry report.)	☐ Yes ☐ No

Testament and family status

a. Did the deceased leave a will? ☐ Yes ☐ No
If "Yes", please enclose the Last Will and provide Executor's particular below.

Name of Executor (as shown in NRIC)	NRIC number
Address	
Contact number (Office) (House) (Hand phone)	

b. Deceased's marital status at time of death ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

(i) Is there a surviving spouse? ☐ Yes ☐ No
If "Yes", please provide details below:

Name of spouse	NRIC number	Date of birth (dd/mm/yyyy)	Address/Contact number

Testament and family status (continued)

(ii) Is/Are there any surviving child(ren)? ☐ Yes ☐ No
If "Yes", please provide details below:

Name of child	NRIC/Birth Certificate number	Date of birth (dd/mm/yyyy)	Address/Contact number

(iii) Please provide details of the parents/siblings below:

Name of family member	NRIC/Birth Certificate number	Date of birth (dd/mm/yyyy)	Relationship with Deceased	Surviving? (Yes/No)	Address/Contact number

If death occurred as a result of an accident

Date of accident (dd/mm/yyyy)	Time of accident

Place of accident

Detailed description of the accident

a. Were there any eye-witnesses to the accident? ☐ Yes ☐ No
If "Yes", please provide details below:

Name of witness	Address/Contact number	Relationship with deceased, if any

b. Was the accident reported to the police? ☐ Yes ☐ No

If "Yes", please provide the name of police station at which the accident was reported and the name of police officer in-charge, and enclose a copy of the police report.

If death occurred as a result of natural causes (E.g. Illness)

a. Date deceased first presented with symptoms of the illness (dd/mm/yyyy) _____ /_____ /_____

b. Date deceased first consulted a doctor for the illness (dd/mm/yyyy) _____ /_____ /_____

c. Please provide details of doctors who had attended to the deceased for his illness(es) below:

Name of doctor	Name/Address of clinic/hospital	Date(s) of consultation (dd/mm/yyyy)	Reason(s) for consultation

d. Did the deceased suffer from any other illnesses/conditions? ☐ Yes ☐ No
If "Yes", please provide details below:

Details of illness(es)/condition(s)		Date first diagnosed (dd/mm/yyyy)	Name/Address of clinic/hospital

e. Please provide details of deceased's regular doctor(s) and company doctor(s) below:

Name of doctor	Name/Address of clinic/hospital	Date(s) of consultation (dd/mm/yyyy)	Reason(s) for consultation

Other insurances

Was the deceased insured with other insurance company(ies)? ☐ Yes ☐ No
If "Yes", please provide the following information.

Name of insurance company	Policy number	Date of issue (dd/mm/yyyy)	Type of plan	Claim amount	Claim notified (Yes/No)	Claim paid (Yes/No)

Other information

Has the deceased or claimant been bankrupt or insolvent or has executed any deed or transfer for the benefit of creditors since becoming interested in the policy?
If "Yes", please provide details.

Policyholder ☐ Yes ☐ No Details: _____

Assignee ☐ Yes ☐ No Details: _____

Donee/
Court Appointed Deputy ☐ Yes ☐ No Details: _____

Insured ☐ Yes ☐ No Details: _____

Payee's details

Payment to be made to ☐ Company ☐ Others, please provide details below

Name of bank _____ Branch _____

Account number _____

[2] If you provide us with an inaccurate bank account number under this section for the payment of this claim, we shall discharge from all liability under under this claim and not be liable for any losses incurred by you (Please submit a copy of bank book or statement for account verification).

Name of payee (as shown in the bank account)	NRIC, FIN or Passport number (as shown in the bank account)	Relationship to the insured	Nationality	Country of residence

Beneficial Ownership Declaration - *This is NOT a nomination of beneficiaries of this policy*

A Beneficial Owner is defined in the MAS Notice on Prevention of Money Laundering and Countering the Financing of Terrorism as an individual who ultimately owns or controls the customer or the individual on whose behalf business relations are established.

If there is a Beneficial Ownership Arrangement, please
1. Please submit a copy of their NRIC or passport and a completed copy of the FATCA and CRS self-certification form for Individual Account Holder, Entity Account Holder or Controlling Person available here: www.income.com.sg/Policy-downloads-and-forms; and
2. Provide details below:

Name of Beneficial Owner	NRIC/Passport number/FIN	Date of birth (dd/mm/yyyy)
Nationality	**Gender**	**Relationship to Proposer**
☐ Singaporean ☐ Singapore PR (Nationality) _____ ☐ Others _____	☐ Male ☐ Female	

Personal data use statement (A photocopy of this authorisation is valid as an original copy)

By providing the information and submitting this application or transaction, I/we consent and agree to Income Insurance Limited ("Income"), its representatives, agents, relevant third parties, Income's appointed insurance intermediaries and their respective third party service providers and representatives (collectively "Income Parties") (referred to in Income's Privacy Policy at http://www.income.com.sg/privacy-policy) to collect, use, and disclose any personal data in this form or obtained from other sources, including existing personal data provided and any future updates, (collectively "personal data") for the purposes of processing and administering my/our insurance application or transaction, providing me/us with financial advice and/or recommendation on products and services, managing my/our relationship and policies with Income including sending me/us corporate communications and notices on updates and servicing, research and data analytics, and in the manner and for the purposes described in Income's Privacy Policy.

Where the personal data of another person(s) (for example, personal data of my family, employee, payee/payer or beneficiary) is provided by me/us or from other sources to Income Parties, I/we represent and warrant that:

- I/we have obtained their consent for the collection, disclosure and use of their personal data; and
- I am/we are authorised to give any authorisation, approval and consent on their behalf to collect, use or disclose, their personal data,

for the purposes as set out in this Personal Data Use Statement.

For the purpose of this application and any claim in connection with my/our policy(ies) with Income, I/we also authorise, agree and consent to (whether this application or transaction is accepted or refused) the following:

a) The medical source, insurance office, reinsurer, or organisation to release to Income any medical or relevant information to do with me or the insured;
b) Income to collect from and/or disclose to any medical source, insurance office, reinsurer, or organisation any medical or relevant information to do with me or the insured; and
c) Income or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests for Income to underwrite and evaluate me or the insured health status or condition in relation to this application and any claim in connection with my/our policy(ies) with Income.

When submitting a claim for an insurance policy, I/we consent and agree that the personal data will also include any subsequent information collected on health or any information that is necessary for Income to decide whether to pay the claim, such as test results, medical examination results, and health records from medical sources such as medical examiners or laboratories.

I/We authorise, consent and agree to the following:

- Income Parties to collect from and/or disclose to the group policyholder, the personal data for all the relevant purposes listed above and in Income's Privacy Policy including to respond to enquiries from the group policyholder for the purposes of this application and policy servicing matters, including confirmation of eligibility for the cover; and
- The group policyholder to disclose the personal data to Income Parties for all the relevant purposes listed above and in Income's Privacy Policy.

Please refer to Income's Privacy Policy for more information, including access and correction of my personal data and consent withdrawal.

Declaration and authorisation

I certify that the information in this form is true and complete and I have not withheld any material information.

I confirm that I understand and agree to the collection, use and disclosure of my personal data as stated in the 'Personal data use statement' (PDUS) above.

For the purposes of policy administration including processing and investigating this claim, and deciding whether Income is to insure or continue to insure me for my insurance applications or policies,

a. I authorise any person or organisation who has relevant information pertaining to this claim, including any medical practitioner, health care provider or institution, insurance company, and investigative agencies, to release and exchange such information (including personal health information) requested by Income and/or its claims service providers.
b. I authorise Income and its claims service providers to collect, use, disclose and to exchange with the persons or organisations listed above any information (including personal health information).
c. I am authorised to disclose information (including personal health information) about the insured person if this claim is made on behalf of them.

I confirm that all documents submitted to Income including bills and invoices are copy of the original documents and I am aware that I am required to retain all original documents for a period of 6 months from claim submission date for verification by Income when required. I am aware that Income may reject my claim should it discover that the document(s) that I have submitted is not a copy of the original document(s).

I confirm that I have paid in full all the bill(s)/invoice(s) that I have submitted to Income for reimbursement and I have not made any claim and will not make any claim from any other source for the same bill(s)/invoice(s). If I have made a claim from other source, I agree that I will provide a copy of the settlement agreement between me and such other source. I am aware that Income will not reimburse me if I have received a full reimbursement from any other source.

If I do not receive full reimbursement from other source, I am aware and understand that Income will only reimburse me the balance of the bill/invoice that has not been paid to me by other source. In the event Income has made a reimbursement to me and I have claimed from other sources and be reimbursed for more than what I incurred in total, I agree that Income has the right to recover any payment made by Income to me.

I agree that a photocopy or electronic version of this authorisation shall be as valid as the original.

Name of deceased (as shown in NRIC, FIN or Passport)	NRIC/Passport/Birth Certificate number
Name of nominee/claimant/the legal personal representative of the policyholder	NRIC/Passport number
Relationship to deceased	
Address	
Contact number (Office) (House) (Hand phone)	
Signature/thumbprint	Date (dd/mm/yyyy)

For group policyholders only

Name of employee (if different from deceased)	NRIC/Passport number
Name of company/school/centre	Address of company/school/centre
Date joined company (dd/mm/yyyy)	
Date of last drawn salary (dd/mm/yyyy)	
Please furnish a copy of latest pay slip of the deceased (If sum assured is based on salary).	

Name of authorised officer/representative of school/centre	Contact number	Email
Signature		Date (dd/mm/yyyy)
Company/school/centre stamp		