



**AIA SINGAPORE  
CITIBANK CREDIT INSURE & CREDIT INSURE GOLD  
DEATH CLAIM FORM  
Corporate Solutions**

3 Tampines Grande, #07-00, AIA Tampines, Singapore 528799, Email : sg.eb.claims@aia.com

## **CLAIMS PROCEDURE**

Please furnish the following documents within 90 days from date of death :-

- a) Duly completed Section 2 of the Claim Form (to be completed by Claimant / Next-Of-Kin)
- b) Copy of Death Certificate
- c) Copy of Police Report/Investigation Report/Post Mortem/Autopsy Report including Toxicology Report (if any)
- d) Copy of Coroner's inquest / Verdict (if any)
- e) Copy of Claimant's/Next-Of-Kin's identity card\* (front and back)
- f) Copy of Claimant's/Next-Of-Kin's proof of relationship to the Deceased\* (For example: Marriage Certificate/Birth Certificate/Letter of Administration/Grant of Probate)
- g) Copy of Deceased's last Citibank Billing Statement prior to date of death and copy of the Billing Statement for the following 2 months

## **IMPORTANT NOTE**

- AIA will request for the Physician Statement if there is insufficient information on the submitted documents.
- Cost of Physician Statement and/or medical evidence shall be borne by Claimant / Next-Of-Kin.
- AIA reserves the right to pursue or obtain further information / document should it be deemed necessary.
- Any other terms and conditions, please refer to the Credit Insure / Credit Insure Gold Certificate.



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**Section 1 – To be completed by Citibank**

To provide a copy of the billing statement for all eligible credit facilities prior to date of death and the following two months.

Part A : Insured Person's Particular		
1) Name of Insured Person		Insured Person NRIC / Passport No.
Date of Birth (DD/MM/YY)	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Contact No.
Address of Insured Member for Correspondence		
Part B : Eligible Credit Facilities		
Date of Event (DD/MM/YY)	Policy Status <input type="checkbox"/> In Force <input type="checkbox"/> Terminated	
Credit Card No.	Coverage Commencement Date	
Credit Card No.	Coverage Commencement Date	
Credit Card No.	Coverage Commencement Date	
Ready Credit A/C No.	Coverage Commencement Date	
Others.	Coverage Commencement Date	
Part C : Completed & Verified By		
_____		_____
Name of Citibank Officer		Signature
_____		_____
Designation		Date



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**Section 2 - Claimant's Statement**

Part A : To be completed by Claimant / Next-Of-Kin		
Name of Claimant / Next-Of-Kin	Claimant's / Next-Of-Kin's NRIC / Passport No.	
Relationship to Insured Person	Contact No.	
Address for Correspondence		
Name of Deceased	NRIC / Passport No.	Date of Birth (DD/MM/YY)
Part B : Declaration and Authorisation		
<p>1) I/We acknowledge and accept that the furnishing of this form, or of any other forms supplemental thereto, by AIA Singapore Private Limited ("AIA Singapore") is neither an admission that there was any insurance in force on the life in questions, nor an admission of liability nor a waiver of any of its rights or defences.</p> <p>2) I/We</p> <p>a) hereby declare that I/we are duly authorised to make this claim and all statements and responses whether on this form or otherwise together with any required questionnaire, amendments, materials and supporting documents submitted in connections with the claim and the Policy ("Information");</p> <p>b) declare that all information is complete, true and correct and that no information or materials have been withheld and that AIA Singapore will rely and act on the Information accordingly. Otherwise, AIA Singapore shall be at liberty to deny liability or recover amounts paid whether wholly or partially;</p> <p>c) acknowledge and accept that AIA Singapore shall be a liberty to deny liability or recover amount paid, whether wholly or partially, if any of the information is incomplete, untrue or incorrect in any respect of if the Policy does not provide cover on which such claim is made; and</p> <p>d) acknowledge and accept that AIA Singapore expressly reserves its rights or obtain further information as it deems necessary.</p> <p>3) I/We hereby authorize, agree and consent to AIA Singapore to request from any hospital, physician, person or organization, all information with respect to any illness, injury, medical history, and copies of all hospital or medical records concerning myself at any time and authorize the prior mentioned organizations to disclose all such information to AIA Singapore.</p> <p>4) I/We consent to AIA Singapore, its associated persons/organisations, third party service providers and representatives, whether within or outside Singapore (collectively "<b>AIA Persons</b>") to collect, use, disclose, store, retain and/or process (collectively, "<b>Use</b>") all personal data and information ("<b>Personal Data</b>") provided to AIA Persons or that they possess about me/us, in the manner and for the purposes described in the AIA Personal Data Policy ("<b>PD Policy</b>") which is available on AIA Singapore's website.</p> <p>5) I/We agree to accept the provisions in the PD Policy as amended from time to time. Where Personal Data of another person is disclosed by me/us, I/we confirm that I/we have obtained the consent of the individual concerned, except to the extent such consent is not required under relevant laws to collect, use and/or disclose such Personal Data. I/We waive (on my/our own behalf and on behalf of each such other person) any right to claim against any of the AIA Persons for any Use in the nature of or for the purposes described above or in the PD Policy. I/We will indemnify AIA Persons for all losses and damages if I/we breach these provisions.</p> <p>6) This consent shall bind my/our successors and assignees, and remains valid, notwithstanding death, irrespective of whether or not our Application/form is accepted by AIA Singapore. A photocopy of this consent shall be valid and effective as the original.</p>		
_____ Signature of Claimant / Next-Of-Kin		_____ Date (DD/MM/YY)
Part C : To be completed by Witness		
Name of Witness	NRIC / Passport No.	
Signature of Witness	Date	



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**Section 3 - Physician's Statement – For Death Claim**

To be completed by Attending Physician (The medical report fee, if any, will be borne by the Claimant)			
Name of Deceased	Occupation	NRIC / Passport No.	
1) Date of Death	2) Place at time of death		
3) What was the immediate Cause of Death?	4) How long has the illness existed prior to Death?		
5) Did Deceased have any symptoms prior to Death? <input type="checkbox"/> Yes <input type="checkbox"/> No  If Yes, Date symptoms first started :  Nature of Symptoms :	6) When did Deceased first consult you for this condition?  Date :  When did Deceased last consult you for this condition?  Date :		
7) When was the diagnosis leading to the cause of Death first diagnosed?  Date :	8) Was Deceased informed of the diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No  If Yes, when was the Deceased first told? :		
9) Did Deceased suffer from any other illness?			
Illness	Period Of Illness	Date of Diagnosis	Date & Type of Treatment
10) Was the Death in any way partly attributed to Deceased's habits, family history, occupation OR previous diseases? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give details :			
11) Was there any predisposing caused of the deceased's death in his / her habits (use of alcohol, narcotics, etc) family history, occupation or previous sickness?			
12) Name and address of all physicians who previously consulted by Deceased for the above condition.			
Name of Physician	Name & Address of Clinic	Date of Attendance	
I hereby declare that I was physician in attendance during the last illness of the deceased and that the foregoing answers are true to the best of my knowledge and belief and that no material fact has been concealed from the Company.			
_____		_____	
Signature of Physician / Surgeon		Date (DD/MM/YY)	
_____		_____	
Name / Designation		Name and Address of Clinic / Hospital & Stamp	