



**NTUC INCOME INSURANCE COOPERATIVE LIMITED**

MAIN OFFICE: 75 BRAS BASAH ROAD, NTUC INCOME CENTRE, SINGAPORE 189557  
 TEL: 6336 3322 • FAX: 6338 1500 • EMAIL: email@income.com.sg • WEBSITE: www.income.coop

**DEATH CLAIM FORM (Individual and Group Life Medical Policies)**

For assistance, please call Life Claims Department at 6330 1648 or email us at lc@income.com.sg

Please complete this form in FULL and attach the following documents:

1. a copy of the death certificate
2. original policy document/insurance certificate
3. copy of marriage or birth certificate if claimant is spouse or child

Policy No. <b>0000002799</b>	Claim No.
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**PARTICULARS OF DECEASED**

Name	NRIC No.
Occupation	Date last at work (DD/MM/YY)
Name of (living) spouse	NRIC No.
Address	
Postal Code	
Contact No. (H) _____ (O) _____ (Pgr/Hp) _____	
Did the deceased leave a will? <input type="checkbox"/> Yes <input type="checkbox"/> No	How many of the deceased's children are living? Above 21 years _____ Under 21 years _____

**DECEASED'S MEDICAL CONDITION/HISTORY**

Type of illness/injury leading to death	Date of accident (DD/MM/YY) - if applicable
Date when symptoms first appeared (DD/MM/YY)	
Describe symptoms/how accident occurred	
Has this condition/injury been treated before? <input type="checkbox"/> Yes, please provide date of first consultation. (DD) _____ (MM) _____ (YY) _____ <input type="checkbox"/> No	
Name, contact number and address of attending doctor	
Name, contact number and address of referring clinic	
Name, contact number and address of regular doctor	

**OTHER INSURANCE**

If deceased was covered under any other insurance plan, please indicate names of Insurance Company(s):

Has the assured or the claimant been bankrupt or insolvent or has executed any deed or transfer for the benefit of creditors since becoming interested in the policy? If so, please give details.

**DECLARATION**

I hereby declare that the above statements are true and complete and I have not withheld any material fact from NTUC Income. I consent to NTUC Income obtaining medical information from any doctor the deceased had consulted and I authorise the giving of such information.

I hereby consent to the transfer and disclosure, at any time and without notice or liability to me of any medical information on the deceased life assured in the Insurer's possession to the Central Provident Fund Board for:

(a) the purpose of making of a claim under the Dependents' Protection Insurance Scheme or any other insurance scheme referred to in the Central Provident Fund Act (Chapter 36) which the deceased life assured may be insured under, or

(b) any purpose connected with the administration or operation of the accounts maintained by the Board for the deceased life assured under the Central Provident Fund Act (Chapter 36).

I agree that a photocopy of this form shall be as valid as the original.

Name of deceased	NRIC No.
Name of informant (next-of-kin above 21 years old)	NRIC No.
Relationship to deceased	
Address	
Postal Code	
Contact No. (H)	(O) (Pgr/Hp)
Signature	Date

**FOR GROUP POLICYHOLDERS ONLY**

Name of member/employee (if different from deceased)	NRIC No.
Name of company/union	Date joined company/union (DD/MM/YY)
Name of authorised officer	Contact No.
Signature	Date
Company/union stamp	
Payment to be made to: <input type="checkbox"/> Company/Union <input type="checkbox"/> Others; please indicate:	
Name: _____	NRIC No.: _____
Relationship to deceased (please attach proof of relationship): _____	